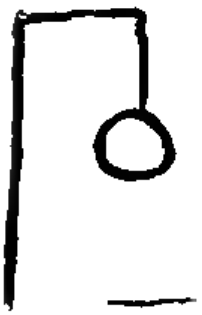
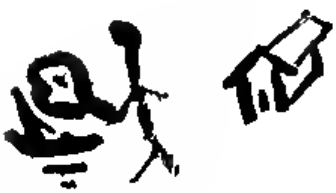



HYPNOGRAPHY

A Study in the Therapeutic Use of Hypnotic Painting


An ill-favoured thing, sir, but mine own

—*As You Like it*—
ACT 5, SC. 4

Thoughts are but playthings of the mind,
A toy strewn here and there
As leaves before the autumn wind,
Scattered, I know not where.

How Distant the Stars
AINSLIE MEARES

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A Study in the Therapeutic Use of Hypnotic Painting

By
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PREFACE

This volume is offered as a clinical study in the therapeutic use of hypnotic painting, and related phenoma It is essentially a clinical study It is in no way the result of a research project in the ordinarily accepted meaning of the term The material is merely the recorded observations of patients under treatment About nine-tenths of the work came from the observation of patients treated in the course of private practice, the remainder comes from work done in the psychiatric department of a general hospital

No patient has been hypnotized for purely experimental purposes In the practice of what might be called eclectic psychiatry, patients whom it was thought would be best helped by hypnosis have been hypnotized, and others have been treated in waking psychotherapy, or by physical methods Suggestibility has never been taken as a criterion for using hypnosis Of the patients who were hypnotized, only those requiring insight therapy have been treated with hypnography

As a result of this, the present work is open to all the criticism which usually pertains to a clinical study There are no measurements, there are no statistics, there is no control series On the other hand, it is confidently believed that other workers using the same method would produce similar results In fact, it is hoped that others will test the technique, perhaps expand it, perhaps integrate it into a useful method of treating nervous illness

A feature of this work has been the persistence with which dynamic aspects of the situation have kept coming to the fore This has applied both to the induction of hypnosis, and also to the ventilation of psychological conflicts These have been described, and they have been explained as purposive, mainly on the basis of unconscious motivation The work is primarily descriptive so that the proof or otherwise of such explanations may rest with other observers

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Chapter 1

INTRODUCTION

minister to a mind diseased
Pluck from the memory a rooted sorrow
Raze out the written troubles of the brain
Macbeth Act 5 Sc 3

1 RECENT HISTORICAL BACKGROUND

In order to understand the present work, it is necessary to know something of the immediate background of medical hypnosis

Traditionally the place of hypnosis in medicine has been confined to the removal of symptoms by hypnotic suggestion Bernheim established a wide reputation for this mode of therapy From his own description, it was an extremely authoritative form of treatment Prestige and authority were used to master the patient in hypnosis, and when the mastery was complete, the symptoms were dispelled by command

In 1889, Freud visited Bernheim at Nancy, and studied his methods He later proceeded to the International Congress on Hypnotism at Paris During the next few years Freud translated Bernheim's works into German, and went so far as to add a preface of his own It would seem from this, that at this stage in his career, Freud was not opposed to authoritative hypnosis

Freud at this time was working with Breuer, who was using his cathartic method based on abreaction The two men practised this technique It would seem that Freud became more and more interested in the recall of past memories Then, following his experiences with the patient, Lucie R , he evolved the method of recalling past memories in the waking state by free association Freud then abandoned hypnosis altogether, and proceeded with the studies which grew into the formulation of psycho analysis

Over the last half-century, the leading medical schools of the

western world have become more and more orientated towards psycho-analytical concepts. The fact that the founder of psycho-analysis had tried hypnosis and found it wanting, seems to have provided a general deterrent to further investigation in this field. But, in the few years since the last world war, there has been a change. In the hope of reducing the great time and cost of formal psycho-analysis, there has been a movement of some analytically trained psychiatrists towards a return to hypnosis. It is interesting that this return to hypnosis has been initiated by the analytical group, which for a half century had been so opposed to hypnosis.

This has led to attempts at revaluation of Freud's motives in abandoning hypnosis. Freud himself gave as his reason that he was unable to hypnotize all his patients satisfactorily, and that many of the patients treated by the cathartic method subsequently relapsed. Some workers now regard these reasons as rationalizations.

Nevertheless, the advent of psycho-analytically trained workers in the field of hypnosis has changed the whole concept of hypnotherapy. In place of the authoritative induction of hypnosis, new passive techniques have been evolved. In place of symptom removal by suggestion, therapy is based on insight. This type of treatment is known as hypno-analysis. It is ordinarily carried out by means of the hypnotized patient's verbal ventilation of repressed conflicts.

2. THE ORIGIN OF HYPNOGRAPHY

A few years ago I was treating a patient in hypno-analysis. On one particular occasion, when he was deeply hypnotized, it seemed that he was trying to say something but was unable to do so. By chance I picked up a pencil which was on the desk beside him, and told him to draw what was in his mind. To my surprise he took the pencil and started to draw all manner of objects which I could not properly understand. While he was still hypnotized, I asked him about the objects he was drawing. From what he said it became clear that he was drawing things that were somehow connected with childhood conflicts. More than this, the conflicts expressed in this way had not been venti-

lated during considerable waking psychotherapy and narco analysis, as well as verbal hypno analysis I was very impressed with this The procedure was repeated with this patient, and with other patients who were being treated in hypno analysis In most cases, with very little encouragement, the patient would draw the outline of some object which was connected in some way with his inner conflicts

It was found that the hypnotized patient usually holds the pencil very loosely This often resulted in only a very indistinct mark being made on the paper Experiments with a heavy black crayon were not much better On the other hand, it was found that hypnotized patients could express themselves quite well graphically by painting with black paint Various attempts to introduce colour by means of crayons or coloured paint, were not very rewarding It was found that the patient would often continue to use the one colour, unless almost continuous sugges tions were given that he could use other colours It seemed that the technical difficulties in using colour far out weigh any ad vantage as a means of expression In fact with some patients it appeared that there was considerable loss of colour sense in hypnosis

Eventually, a fairly standardized technique was evolved in which the patient projects his psychic material by painting in black paint on white paper, and while he is still hypnotized his associations are obtained to the objects which he has painted This process has become known as hypnography

Chapter 2

THE PRELIMINARIES

Cleanse the stuff'd bosom of that perilous stuff
Which weighs upon the heart.
Macbeth Act 5, Sc. 3

The first step in the process of hypnography is the induction of hypnosis, but before this can be attempted there are certain very necessary preliminaries which must be fulfilled. In the natural desire to get on with the more obvious aspects of helping the patient, there is a tendency to neglect these preliminaries. They are so simple that their importance is overlooked; but on them, as much as on anything else, depends the success or failure of subsequent treatment.

1. HISTORY-TAKING IN RELATION TO HYPNOSIS

No attempt will be made to discuss the general aspects of the dynamics of the initial interview, or the techniques of history-taking. Our present concern is only with those particular features of the subject which relate to hypnosis.

It is general psychiatric practice for the therapist to maintain an initial attitude of passivity at the commencement of an interview with a new patient. As the interview proceeds, the patient's emotional needs become clear. From his initial passivity the therapist is then in a position to change his attitude according to the psychological demands of the interview situation. Very often he will maintain his passivity. Sometimes he may adopt paternal or sibling roles, or if the patient is in need of advice he may become authoritative. When it seems that the patient will require hypnotherapy, the subsequent treatment can be greatly facilitated by the therapist's early adoption of the appropriate role. If it happens that the patient needs suggestive hypnotic treatment, it is wise for the therapist, at an early stage,

to assume an attitude of authority, and to encourage factors to develop in the interview situation which lead to an assumption of prestige The present discussion however concerns hypnoanalysis as distinct from hypnotic suggestion This involves the passive induction of hypnosis, and the passivity of the therapist

If we aim to induce the patient to abandon control voluntarily in passive hypnosis, he must be led to the proposition slowly He must be conditioned to the idea of letting himself go The process must be slow and casual, or else critical intellectual faculties become active, and the patient comes on guard as it were The interview is so structured as to facilitate the subsequent induction of hypnosis The patient is quietly encouraged to disclose himself, to let himself go, to abandon himself in the telling of his story This applies not so much to the detailing of the facts of his life history, but rather to the disclosure of his own emotions, his deep anxieties and his guilt feelings This is not brought out by direct questioning by the therapist It is achieved by subtle non-verbal and extra-verbal communication The patient's anxieties are actually seeking ventilation, but this ventilation is prevented by defence mechanisms, such as amnesia and denial, which function to save the patient the hurt of full awareness of his inner conflicts Direct questions from the therapist have the effort of alerting these defences, so that ventilation becomes more difficult The therapist needs to be friendly and passive In place of direct questions the patient is led to the traumatic areas of conflict by such means as gesture, unverbalized phonation, or by the repetition of some phrase previously used by the patient In the history taking it is very characteristic of the psychoneurotic to come spontaneously to a matter of psychological conflict, and then suddenly shy off the subject At this stage a direct question is interpreted as an intrusion The patient becomes defensive, and is immediately on guard against letting himself go On the other hand in a few minutes time the patient may be brought back to the subject by the mere repetition of some word or phrase By these means the patient is gradually conditioned into the procedure of abandoning himself

Above all else, the smooth induction of hypnosis by passive

methods requires the patient's confidence in the therapist. There is a need for unlimited trust. This only comes when the patient begins to feel that he is getting to know the therapist. This process takes place mainly during the history-taking, so it is important that the patient be given the opportunity to get to know the therapist. This of course does not involve getting to know the therapist in any social sense of the word. It means getting to know him for what he is, that is, a man who can be trusted, and who will respect any trust that is given him. This cannot happen in five or ten minutes. Even if the relevant particulars of the history can be quickly ascertained, or, as frequently happens, the referring doctor sends a full history, the patient on his part must be allowed adequate time to assess the therapist. It is important to remember that the process cannot be expedited by any active measures by the therapist. Trust is only formed by oblique, intuitive and extra-logical mechanisms. Any direct approach by the therapist on the lines, "I am a doctor, you can trust me," only seems to place an emotional barrier between patient and therapist. Needless to say, the referring doctor can pave the way for the patient to put his trust in the therapist, by speaking of him with respect.

Besides trust, there must be realistic confidence. This means that the history-taking must be sufficiently thorough to give the patient the confidence that the therapist knows all about him. The therapist must not be content with satisfying his own requirements, or leaving areas which the patient regards as important to be explored during later treatment. If this is done, the patient is left with doubts.

In hypnosis by passive methods, there must be no holding back. If there is any holding back in the first interview, there will be difficulty later. Accordingly, in the history-taking, it is very important that the patient discloses his real symptoms and his real fears. It is not uncommon for a patient to present screen symptoms. It may be that he complains of headache. It is a real symptom; he suffers from headache, but the symptom that brought him to consultation is a sexual difficulty. He feels diffident about discussing this, so mentions only the headache, with a view to mentioning the real symptom later on. The history-

taking must be adequate to ensure that the patient discloses his real problems and does not offer mere screen symptoms If the pattern of holding back is allowed to develop, the patient is likely to hold back from the abandonment which is necessary for hypnosis by passive methods

This leads to the element of confession which is often present in history-taking When a patient confesses guilt, he develops a bond with the person to whom he makes confession A bond of this type is an aid in hypnosis, so the history-taking is managed in such a way as to give full opportunity for the confession of guilty secrets

When history-taking involves traumatic areas of the type indicated, the patient often vents considerable emotion as he tells his story This abreaction helps to form a relationship with the therapist which is later of advantage in hypnosis It is a clinical impression that patients who abreact during history-taking are usually more easily hypnotized

There is another way in which the history-taking can be used to facilitate subsequent hypnosis Most patients will be hypnotized by techniques in which the therapist plays a fairly passive part, but there are some patients who are better helped by a more authoritative attitude on the part of the therapist These patients can usually be picked quite easily With them the interview is now structured so as to place the therapist in the position of an authoritative figure He assumes an air of confidence The patient's innermost secrets are not sought obliquely, they are simply demanded The situation has gradually changed from the man to man affair at the start of the interview Equality is lost It is now a question of a vastly superior being interviewing an inferior The authority of the therapist is accepted more and more by the patient, so that there is an easy transition to hypnosis by authority

On the other hand, if it is seen that the patient will need a particularly passive induction, the dynamics of the interview are changed so that the therapist is always passive and permissive Difficult areas of the history are explored obliquely The patient is encouraged to take charge of the interview He chooses the topics He sets the pace He thus gets the confidence to let

himself go. When the time comes he is the better able to abandon himself to a passive method of induction.

Difficulties of course arise. A common one is that the patient endeavors to keep the interview on a superficial plane. He may adopt a drawing-room or cocktail-party manner; or he may give a detailed factual account of his life and at the time remain emotionally aloof from it all. These attitudes of the patient are, of course, defences. They are adopted to save the patient the pain of experiencing the appropriate emotion. It is very important that such defences are not allowed to continue, for it means that the patient is guarding himself, and is not prepared to abandon himself in the way which will be required in passive hypnosis. This situation demands some active intervention on the part of the therapist, otherwise the interview will degenerate into superficialities. There are two moves, either of which is often successful. One is to deliberately provoke the patient to the expression of some emotion. The giving way to emotion itself in this way is a stepping stone towards the letting go of the self in passive hypnosis. In order to involve the patient emotionally it may be necessary to bring the patient to discuss subjects which are likely to cause him distress. Once the patient has been provoked to emotion on one subject, he will usually vent his emotion in relation to other conflicts quite spontaneously.

The other way of dealing with the situation when the patient is defending himself by keeping the interview on a superficial level is to proceed immediately to the physical examination. This has the immediate effect of confronting the patient with a medical situation in place of a social interview. The laying bare of the body is of considerable symbolic significance, and it certainly makes the laying bare of the mind so much the easier. Many men who harbour deep-seated sexual guilt about masturbation, promiscuity or homosexuality believe that a doctor can tell what they have been doing from a casual inspection of the genitals. In such cases physical examination tends to break down the barriers, and then the patient will quite often ventilate his guilt. Surprisingly enough, this process operates in the educated and sophisticated as well as in the lower class patient. In general, patients who have been examined physically abandon them-

selves more easily to passive hypnosis, than those who have not been subjected to bodily examination

Silences are always a difficulty in the interview situation There is a tendency with many authors to allow long silences rather than help the patient out This is often very distressing to the patient His resentment is aroused, and hostile feeling may develop towards the therapist Although such feelings can be handled in psychotherapy, they are a hinderance to the induction of hypnosis Accordingly, it is wise in history-taking to help the patient in difficult areas rather more than is the custom in analytical techniques in waking psychotherapy

2 THE ESTABLISHMENT OF RAPPORT

Authoritative methods of hypnosis are not dependent to any great extent on the prior formation of rapport with the subject With these methods it is authority and prestige which are important The subject is overwhelmed The more exalted is the status of the therapist, the easier the induction of hypnosis

As distinct from this, rapport is an essential prerequisite for the induction of hypnosis by passive methods Rapport is the affective relationship between patient and therapist by which passive treatment becomes possible It is an emotional process and is formed by emotional rather than intellectual mechanisms Rapport is established by means of the emotional concomitants of the intellectual and physical processes of history taking and physical examination

For passive hypnosis the patient must have absolute confidence in the therapist, otherwise he is unable to abandon himself sufficiently, he is unable to let himself go, he is unable to surrender ego control This confidence cannot be obtained from any logical, intellectual assessment of the therapist by the patient Of necessity it is the emotionally determined confidence of rapport In a final analysis it seems that rapport depends on the patient's intuitive assessment of the psychic integration of the therapist From the practical point of view, the matter resolves itself around two factors, the psychological adjustment of the therapist, and the means of presenting this in its most

favourable light to the patient. At the moment we are only concerned with a few aspects of the latter.

Absolute confidence is needed in both the ability and the sincerity of the therapist. The first requirement is that the therapist does in fact, possess these qualities. The second is that the patient has confidence in them. An intellectual awareness of the therapist's attributes is not enough. The nature of the confidence which is required is rather a feeling of confidence, a feeling of security. This is a matter of the emotions. Not all therapists, who are sincere and able, have the capacity to give patients this kind of confidence. Inasmuch as the process is emotionally determined, there is nothing logical that the therapist can say to convince the patient. It is not the logical content of what he says, but only the way he says it, and the oblique or symbolic meaning of the speech which is effective. This is one of the means by which rapport is established. Later this process is continued into the passive induction of hypnosis when it will again be seen that it is not the logical meaning which is important. In fact, the affective relationship between physician and patient en rapport merges into a similar affective relationship between hypno-analyst and patient in passive hypnosis.

At the first meeting with the patient, the initial passivity of the therapist is important. This allows the patient to set the pace, to take charge if necessary. By allowing this, the patient quickly shows his hand. Dependent attitudes or aggressive drives which will be utilized in the subsequent hypnosis are disclosed by the patient. The therapist's passivity must not be fixed or rigid, it must have a dynamic quality about it, so that it varies in nature and degree with fluctuations in the interpersonal situation. This dynamic passivity involves changes of attitude according to the demands of the interview.

These varying attitudes which the therapist assumes towards the patient may themselves have a symbolic significance to the patient. For instance, a parental attitude of a male therapist to a male patient who has an incompletely resolved oedipus complex may be useful in waking psychotherapy in that the patient can project his aggression and resentment on to the therapist, so that these negative feelings can be worked through in psy-

chotherapy. But such is not so if hypnosis is contemplated. In this case, the aroused hostile feelings mitigate against the passive induction of hypnosis. The patient feels resentful to the therapist He wants to resist him. He is unable to surrender himself to the therapist for passive hypnosis If, on the other hand, the patient happens to be a dependent person with highly valued paternal ideal, then the same attitude of the therapist may be an aid in the induction of hypnosis. Hence the importance of the early passivity of the therapist in the initial interview, so that the patient's basic personality structure is known before the therapist ventures to assume any specific attitude

3. PRESTIGE

Almost without exception, the earlier writers on hypnosis gave great importance to the subject of prestige Some modern authors continue in the same vein, but many recent works on hypnosis almost ignore the subject It is clear that the matter requires some evaluation The first consideration is that, over the years, there has been a change both in the attitude of the therapist and the type of patient treated The earlier medical hypnotists, like the present day stage hypnotists, relied on authority It is beyond doubt that prestige is very important both in authoritative methods of induction, and in symptom removal by hypnotic suggestion The other factor is that the majority of the patients of the earlier hypnotists were uneducated folk, and the therapist's social inferior In these circumstances the development of prestige would be comparatively easy. The suggestibility of the minority of intelligent, educated patients would be increased by the behaviour of the others

Present day circumstances are quite different Therapists are striving more and more for passive induction Patients are well informed, and do not tend in the same way to regard the therapist as their superior. The extreme over-confidence, and blatant showmanship of former medical hypnotists would not be tolerated these days. To assume an air of omnipotence in the face of an intelligent and highly critical patient would be inviting rejection.

The important question is the assessment of the value of

prestige in passive hypnosis. Remarkably little information is obtainable on this subject in recent literature. We must keep in mind the basic fact in hypnosis; that is, the uncritical acceptance of suggestions. Prestige aids the uncritical acceptance of suggestion, therefore it aids hypnosis by any means, whether active or passive. Because of the undramatic nature of passive induction, the value of prestige is overlooked. Another factor is that there are qualitative differences in the nature of prestige. The type of prestige which aids the hypno-analyst with his passive methods is different from the dramatic, blatant and histrionic type of prestige sought by hypnotists in the past.

Most patients are referred by a colleague, and quite a lot depends on the impression he has given the patient of the psychiatrist. The patient comes to the interview then with some preconceived ideas about the stature of the psychiatrist. It must be assumed that this impression is favourable, or the patient would not consult this particular practitioner. The colleague who refers the patient usually has little knowledge of hypnosis, and it is extraordinary how often some deprecatory remark is let slip about this form of treatment. This has the effect of a negative suggestion, and reduces prestige.

The interview now becomes a testing ground on which it will be proved whether or not the psychiatrist can stand up to the patient's expectations. Generally, the guilty and depressed patient expects little, and is not disappointed. On the other hand, the chronic hysteric expects the knight in shining armour, and is immediately disillusioned. It is aimed to conduct the interview in such a way as to enhance prestige. This is done quietly and subtly. The approach is factual. There is no attempt to impress the patient. There are no unrealistic prognoses, but, if it is true that other patients with a similar condition have been helped, the patient is told so. If a patient is going to be treated by a hypnotic technique, it is very much in his interests that he sould hold the therapist in high regard.

Authoritative hypnosis requires the kind of prestige which over-powers. This facilitates the domination and over-whelming. But there is none of this in passive hypnosis. So the kind of prestige required for passive hypnosis is fundamentally different

from that required for authoritative hypnosis The patient will be asked to let himself go, to let himself go so completely that his body will work automatically Such abandonment of the self, and the relinquishing of voluntary control requires the utmost trust Without trust it is not possible to abandon one's self in this way Accordingly, the kind of prestige needed for passive hypnosis must be based on trust and confidence, not on power. During the interview, above all else, the therapist must present himself as a person who can be trusted This, of course, must be done by oblique means Any direct approach such as telling the patient, "I am your doctor, you can trust me," only has the effect of arousing the patient's critical faculties He is immediately on the alert, an attitude which is the antithesis of trust Likewise, there must be no extravagant claims, no promises As in ordinary life, it is those who have a quiet naturalness of manner who are trusted Our dealings with the patient are friendly and open Unlike the case of prestige for authoritative hypnosis in which the idea of omnipotence is the aim, in this kind of prestige the casual admission of minor failure only adds to prestige by way of increasing trust

4 THE ASSESSMENT OF MOTIVATION

For any form of psychiatric therapy, the patient's motivation for treatment must be assessed This is particularly important when hypnotherapy is contemplated A patient who is inadequately motivated for treatment consciously defends himself against hypnosis, so during the history-taking and physical examination an estimate must be made of the patient's motivation The statement by the patient that he has such and such symptoms and desires relief, is in itself not sufficient The patient may consciously desire to be rid of the symptoms, but at the same time, he may have very good reason for keeping them The reasons for keeping his symptoms may be fairly superficial in the way of secondary gain, or they may be deep-seated

Nearly all patients defend themselves to some extent against hypnosis by unconscious defence mechanisms The inadequately motivated patient is rather different He states that he desires to be hypnotized He believes he is telling the truth, but at the

same time, he is so ambivalent in the matter that he cannot help consciously resisting hypnosis. This in itself does not make hypnosis impossible, but it makes it more difficult. Resistances will be met with not only in the induction of hypnosis, but at every stage of treatment. So it can be assumed at the outset that the treatment of the inadequately motivated patient will be so much the longer and more difficult.

Before commencing treatment, the questions of secondary gain must be fully evaluated. There are the obvious cases of compensation or pension, but many psychoneurotics get very great secondary gain in more complicated ways. Illness may be satisfying a patient's dependent needs, or symptoms may be saving him from a marriage for which he is emotionally unfit. In particular, the motivation of homosexual patients should be thoroughly examined.

Apparent severity of the symptoms is not in itself adequate motivation. If the patient is in psychic equilibrium with his symptoms, it does not matter how gross they are, he often lacks adequate motivation. This is typically so in the case of hysterical conversions of long standing. The patient's whole life, and those around him become adjusted to the symptoms. "La belle indifference" of these patients is a warning that treatment may be difficult.

These are matters of the patient's motivation towards treatment in general. There is also the question of the motivation for hypnosis in particular. When a patient presents himself specifically for treatment by hypnosis, it is wise to examine his reasons for selecting hypnosis in preference to other forms of treatment. On close enquiry it often becomes clear that it is not so much the relief of symptoms which the patient is seeking, but rather hypnosis itself. This is by no means uncommon. The patient may come for hypnosis in order to satisfy an unconscious psychological drive, and the patient is unaware that his symptoms are only a rationalization for the experience of hypnosis. Such patients may have the urge to fulfil their masochistic yearnings in the surrender to domination which they expect to find in hypnosis. There are psychoneurotic patients who delight in going from doctor to doctor, only to boast that no one can cure them.

They frequently seek hypnosis. Such patients are often motivated by sadistic drives. They will ask for hypnosis and then actively resist it. Sometimes they are masculine-aggressive women who resist hypnosis to prove that they cannot be overpowered by a man.

It is not uncommon for early schizophrenic and paraphrenic patients to seek treatment by hypnosis. The motivation of these patients is that they experience feelings of influence. There is the feeling that their mind is being influenced by some outside agency. By being hypnotized they hope to free it of the noxious influence. The matter is sometimes complicated by the patient not disclosing his ideas of influence, and giving some rationalization as to his reason for seeking treatment Psychosis or incipient psychosis is usually regarded as a contra-indication for hypnosis

As distinct from these patients whose motivation is poor, there are patients whose symptoms are associated with psychic distress. These are usually well motivated for treatment in general, and for hypnosis in particular. Distress is more significant than pain Hysterics who complain of pain in a bland way without appropriate affect, may lack motivation for successful hypnotherapy.

5. THE ESTIMATION OF SUGGESTIBILITY

As far as hypno-analysis is concerned, the commonly used tests for suggestibility such as the hand-clasping test and the swaying test, have several distinct disadvantages In the first place, there is a dramatic or bizarre quality about them which rather savours of the variety stage. This in itself is sufficient to alienate the sensitive patient, and in general makes the tests unsuitable for consulting room practice. Again, the introduction of the necessarily authoritative attitude at the very beginning of treatment is technically bad

In addition to this, there is a very real disadvantage in the fact that the patient knows he is being tested. If the patient does not prove to be very suggestible and the tests fail, the therapist is confronted with an inevitable loss of face.

Accordingly, it is a very considerable advantage if an estimate of suggestibility can be made unbeknown to the patient. This is particularly so when the patient has been referred for general

psychiatric opinion, and the question of the possibility of treatment by hypnosis has not been mentioned to the patient.

If suggestibility can be estimated without the patient's knowledge, and the patient does not prove suggestible, then there is no reason why the patient should know that the thought of treatment by hypno-analysis even entered the therapist's mind.

It has become the author's practice first to establish rapport during an unhurried interview in which the patient describes his symptoms, and is given an opportunity to discuss any superficial conflicts which he may care to ventilate. If it is thought that the patient may be suitable for treatment by hypno-analysis, suggestibility is estimated during the ordinary physical examination.

The tendon reflexes are elicited with a heavy, soft plessor. At the same time the patient is told to relax his whole body, to let all his muscles go loose so that the reflexes can be tested. A few minutes can be spent repeating the suggestions, and the elicitation of the tendon reflexes is continued in a leisurely manner so that the patient believes his relaxation is to aid the examination. The suggestions can be modified by telling the patient, "You don't move your legs, they are quite loose, it is I that move them." So saying, the limb may be moved about passively, or moved reflexly by the knee-jerk.

Three types of response to these suggestions may be observed. Some patients give a positive response; they relax more or less completely. The muscles are flaccid. The limbs can be moved passively without inducing tension in the muscles. As the patient is lying on his back with his legs extended, this is conveniently tested by rolling the leg inwards with the hand on the calf. If there is good relaxation, as soon as the leg is released, the weight of the foot rolls it back to the normal position. The relaxation in these patients, who give a positive response, usually extends to the face. This is shown by a general smoothing of the facial wrinkles. The forehead is ironed out. The naso-labial folds are less pronounced. There may be a slight separation of the lips. A gradual narrowing of the parpebral fissure is a very significant positive sign, as is a spontaneous relaxed closure of the eye-lids.

A purposive shutting of the eyes has either no significance, or may indicate tension

Patients who respond thus are suggestible, and are easily hypnotized by suggestions of relaxation At the next session the same procedure is repeated Suggestions of heaviness and immobility are included with the suggestions of relaxation Immobility of the legs, arms and eye-lids is induced and challenged

Other patients make very little or no response to the suggestions of relaxation during the testing of the tendon reflexes They remain objective about the whole procedure They often make conversation consistent with normal politeness Their muscles retain a good deal of tone No change can be noticed in their facial expression

These patients can usually be hypnotized, as can almost anyone, but it is probable that they will take several sessions before sufficient depth can be obtained for *hypno-analysis* whereas those who react positively usually reach sufficient depth by the second or third session In general this group is more difficult to handle in hypno analysis, and it might be thought wise to consider some other form of psychotherapy

Some patients, instead of becoming more relaxed with the suggestions of relaxation, actually become more tense The tone in their muscles increases When the therapist puts his arm under their knees to elicit the knee-jerks, their heels often lift up off the couch They are inclined to be restless They cannot get comfortable There is a tendency to wriggle about and fidget Tension is seen in their facial expression The patient is aware of his inability to relax and the more the suggestions are repeated, the greater is his discomfort and the greater the tension

The important thing about such patients is that they are influenced by the suggestions They are influenced negatively, but the fact that they are influenced means that they can be easily hypnotized provided a suitable technique is used If the negative response is well marked, they usually cannot be hypnotized by suggestions of relaxation which only provokes increased tension and restlessness On the other hand, they are easily hypnotized by the arm levitation method The general muscular

tension which they experience seems to make it easy for them to lift the arm up into the air when appropriate suggestions of lightness are given.

The estimation of suggestibility by this method has several advantages. The repeated elicitation of the tendon reflexes in itself appears to aid relaxation. The effect is probably produced through the mechanism of non-verbal suggestion.

The association of the reflex movement of the limb with the verbal suggestions accustoms the patient to the phenomenon of the involuntary movement of his limbs in response to suggestion, and so paves the way for hypnosis.

The method has the advantage of not only estimating suggestibility, but of also acting as a reliable guide as to the best method for the induction of hypnosis.

The patient is unaware that he is being tested for hypnosis. If he proves unsuitable, the subject need not be discussed. There is no disappointment of the patient; no loss of face on the part of the therapist. There is nothing to endanger rapport.

6. EXPLAINING HYPNOSIS TO THE PATIENT

Putting the question of hypnosis to the patient can be a matter which requires a good deal of judgment if no anxiety or resentment is to be aroused in the patient. If the practitioner is known to the patient as one who practices hypnosis, or if the referring doctor has mentioned the subject to the patient, then the matter is very much easier. To the majority of the lay public, the idea of hypnosis is still vaguely associated with witchcraft and submission to another's will. Neither stage hypnosis, nor the hypnotic exploits in a popular comic strip has done anything to elevate the procedure in the eyes of the public. No wonder that the patient who is referred to a general psychiatrist, stands aghast at the suggestion of treatment by hypnosis.

Some practitioners, in order to avoid the risk of raising difficulties or mobilizing anxiety in the patient, do not discuss the matter with the patient at all. The patient is hypnotized without his consent and without his knowledge. The therapist rationalizes his conduct by the statement that it is in the patient's interests that his anxiety should not be aroused; and he assumes

that the fact of the patient coming to him for consultation is a tacit authorization to proceed with treatment The author could not disagree with this procedure too strongly

Such a procedure is dishonest Although it solves an immediate problem to the patient's advantage, it is hard to imagine how it can benefit the patient in the long term view The patient's confidence in the therapist must be based on something real and factual It is felt that the therapist should be scrupulously straight-forward in his dealing with patients, and that no momentary advantage to the patient can warrant deviation from this code

The conclusion is that the patient must be told about hypnosis, and his consent obtained prior to starting treatment The next problem is whether it is justifiable or not, to briefly discuss hypnosis, obtain verbal consent, and then immediately hypnotize the patient. This procedure satisfies any qualms about straightforward dealing with the patient, and also puts the therapist in a reasonably sound medico-legal position Nevertheless, there is an element of rushing the patient into treatment His consent is obtained, but he is not given much chance to evaluate the matter in cold blood Accordingly, it is thought better to discuss the question of hypnosis, but not to proceed to treatment on the same day This means that the patient can go home, think about the problem, and if he desires, discuss it with relations or friends, or the family doctor It might be thought that allowing patients so much liberty would mean that many would reconsider their decision, and decline treatment Experience has shown that this is not so

With hypnosis, there is considerable danger in regarding any detail as trivial From the start of the initial interview, it is the attention to detail which determines the success of treatment It seems that the precise expressions used to present the idea of hypnosis to the patient are sometimes very important It is not sufficient merely to inform the patient that treatment by hypnosis is advised The acceptance of advice is not unlike the acceptance of hypnotic suggestions It is more readily accepted if the ideas are graded and not presented too bluntly

If the patient has reacted positively to the suggestions of re-

laxation used in estimating his suggestibility, he can be told that he relaxed very well while being examined, and that it is thought that he would be helped by a relaxing form of treatment. It would be a similar form of relaxation to that which he has already experienced, only it would be more complete. This type of relaxation is obtained by medical hypnosis. It is just a question of letting one's self go; a complete physical and mental relaxation. It is very different from stage hypnosis, in which very suggestible people are encouraged to do foolish things for the entertainment of the audience. In this relaxed state, there is not only the physical relaxation and mental calm, but worrying ideas can be expressed, ideas which at present are not in consciousness at all, but it is nevertheless these ideas that are the main cause of nervous trouble.

If the patient has responded negatively to the suggestions of relaxation, the proposition will have to be put in rather different terms. The negative response is associated with subjective tension in the patient. This can be used. The tension is distressing to the patient, and provides good motivation for treatment. He can be told that during the examination he appeared tense. He could be helped if this tension were allayed. This could be done by medical hypnosis. It is a question of letting one's self go, so that there is a relaxation of body and mind. In the relaxed state of the body, all the organs and the limbs will just work automatically; and so on. The explanation can be varied according to the intelligence and degree of sophistication of the individual patient.

Before treatment is started, the patient must be given some sort of estimate of the number of sessions that might be required, and an estimate of cost. It would be clearly wrong to accept the patient's consent to hypnosis without first discussing these matters.

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Chapter 3

THE INDUCTION OF HYPNOSIS

Can such things be,
And overcome us like a summer's cloud?
—*Macbeth* Act 3, Sc. 4

The following comments are offered as a guide to techniques which are suitable for the induction of hypnosis for the purpose of hypnography. They are in no way intended as a general account of the induction of hypnosis.

1. CHOICE OF METHOD OF HYPNOSIS

In the first place, as hypnography is a technique in hypnoanalysis, it requires a passive method for the induction of hypnosis. Any display of authority, any dominating or over-powering of the patient is absolutely contra-indicated. On the other hand, it will be seen that some techniques which are traditionally associated with authoritative hypnosis can in fact be used quite passively.

In discussing the estimation of suggestibility on the patient's response to suggestions of relaxation during the elicitation of the tendon reflexes, two different types of response were noted. Some patients become progressively more and more relaxed. Hypnosis by suggestions of relaxation is the method of choice for such patients. A second type of response is given by patients who are tense, and who become progressively more tense as the suggestions of relaxation are continued. It seems that thy are aware of their inability to relax. They try harder and harder. Their increasing frustration raises muscle tension more and more. These patients are easily hypnotized by techniques of arm levitation.

There is also another type of response, a negativistic response. Such patients make a response to suggestions, but it is in the opposite direction to that which is suggested. If it is suggested

that they relax, they fidget With suggestions that they are sleepy and that their eye-lids feel heavy, the eyes are in fact opened a little wider. If arm levitation is attempted, and it is suggested that their hands feel light, from the flattening of the finger pulps it is seen that the hands are actually being pushed downwards ever so slightly on the table Patients who give this negativistic type of response are easily hypnotized by the induction of repetitive movements

There are still other patients, the more difficult ones In general, these fall into two groups There are those who make no response at all to the test of suggestibility These are often individuals who are very well adjusted psychologically, and who have a rather matter-of-fact approach to life The other group consists largely of the other extreme, very insecure persons who are ever alert, and their basic insecurity does not allow them to abandon themselves to passive hypnosis These more difficult subjects are best hypnotized by the dynamic method It is believed that practically any patient who really wants to be hypnotized, can in fact be hypnotized by this method

2 HYPNOSIS BY SUGGESTIONS OF RELAXATION

Rapport has been established with the patient during the first interview, and the matter of hypnosis has been explained The patient is quite clear that there is no mystery about it He knows that the process is merely a continuation of the relaxation which he achieved during the examination on the first visit He is told that he can so relax himself, let himself go to such an extent, that his body will work automatically

People who relax easily can usually do so more completely when lying down, so the patient is asked to lie down on the examination couch It is important that these initial steps are leisurely Any suggestion of hurry mitigates against relaxation Some quiet and casual conversation which does not require the active intervention of the patient is an aid It is often convenient to start with the elicitation of the knee jerks with a heavy soft plessor The patient is told, "You just let yourself relax while I test these reflexes Your muscles are all loose You are quite relaxed You don't move your legs, it is I that move them"

The active participation of the therapist makes the patient's relaxation so much the easier, ever so much easier than if the patient is merely given verbal suggestions of relaxation. On the other hand, this active participation of the therapist is done permissively. There is no question of authority.

The suggestions are continued. "Relaxed, easy, comfortable, all your muscles letting go. Your arms are just lying there. I lift your arm up and it just flops back." So saying, the arm is lifted up and allowed to flop back on the couch. This manoeuvre is more effective if the arm is raised by taking hold of the sleeve rather than the patient's hand. If the patient is not wearing a coat it is best to take hold of the wrist rather than the hand, and the arm is raised by pulling downwards towards the feet as well as lifting up. By this means the arm is raised without bending the elbow. The object of this procedure is to encourage such relaxation that the patient allows his limbs to be moved passively without making any response whatsoever. This is repeated with the legs, and the suggestions of relaxation, calm, and ease are continued. When the stage is reached that the patient allows the completely passive movement of his limbs, a blanket is thrown over him, and the idea of heaviness is incorporated with the suggestions of relaxation. "Your legs are relaxed, all the muscles letting go, relaxed and heavy, heavy. You feel the weight of them weighing down on the couch." The idea of drowsiness is now included. "Everything letting go, relaxed and heavy, heavy relaxation, heavy drowsy relaxation, heavy drowsy relaxation all through you."

The grading of the suggestions is an essential element. During the whole procedure they are carefully graded as to ease of acceptance. The first suggestions must be so easily accepted that there is no possibility of the patient rejecting them. They may commence with what really amounts to an observation of fact. "You are just lying there." Such a statement can hardly be rejected. The next comment may be—"Comfortable, easy, relaxed." As the process continues, more difficult suggestions are given. The acceptance of any suggestion always facilitates the acceptance of a slightly more difficult suggestion. The degree of grading from ease to difficulty of acceptance is determined

by the readiness with which the patient accepts the suggestion It is always better to proceed slowly rather than run the risk of rejection

The aim is for the hypnotic suggestions to follow imperceptibly from casual conversation with the patient In the conversation, and in the initial verbal suggestions conventional syntax is used, and the voice maintains its normal tonal variations As the suggestions proceed the spoken sentences become simpler and simpler, so that finally the suggestions are conveyed by single words with no syntax at all At the same time the voice loses its normal inflexion, and becomes more and more monotonous

The procedure must be kept flexible so that it can be varied to suit the needs of the individual patient At this stage, even patients who relax easily often show some anxiety There is a slight furrowing of the forehead, the lips are a little tenser, or there may be a few restless movements When this happens, the suggestions are switched to calm and ease, comfort and warmth It must be leisurely There is no rushing the patient He is given time for his anxiety to settle down before proceeding with the hypnotic suggestions

A decision must now be made as to what precise form the suggestions will follow The ideas of drowsiness may be emphasized so that the patient drifts into hypnotic sleep If the stress is on the heaviness, then immobility of legs and arms may be induced, or it may be advisable to concentrate on closure of the eye-lids The choice is made according to the patient's psychological needs, and the nature of unconscious defences

This is intimately related to the question of challenging In the induction of hypnosis, every time the patient is challenged to do something, and he either refuses to accept the challenge, or accepts it and fails, he drifts deeper into hypnosis Thus challenging is a very important technique for increasing the depth of hypnosis The difficulty is that the direct challenge is a display of authority, which it is desired to avoid in the passive induction of hypnosis In this respect it is well to remember that any suggestion at all carries with it an oblique challenge by implication Even such a simple suggestion as, "You are relaxed," in a way invites the patient to tense his muscles to see

if they are relaxed. The suggestion, "Your legs are heavy," carries the oblique challenge to move the legs to test the heaviness.

On the other hand, challenging is a great aid in increasing the depth of hypnosis, and in the vast majority of cases, it does not disturb the patient. In the induction of passive hypnosis, the main problem in relation to challenging, is how to challenge and still remain passive. Theoretical considerations concerning the passivity of the therapist in the induction of hypnosis are discussed elsewhere. It seems likely the concept of passivity in relation to hypnosis should be used in a relative sense, and that absolute passivity on the part of the therapist is never attained. In this light, the problem resolves itself into a matter of how to challenge the patient and at the same time remain as passive as possible. Great emphasis can be made of the fact that the patient allows himself to go into hypnosis, and then his body works automatically. "You do it yourself, you let yourself go, you let yourself go completely, you let yourself go so completely that your body works automatically." Expressed like this the challenge is only a way of showing that his body does work automatically. The idea can be further elaborated. "Your body works automatically, it is good when your body works automatically, it means that you have let yourself go completely, it is good, it is the first step to getting well." Suggestions of heaviness of the legs can be given and then the patient challenged. "Your legs are heavy, so heavy you cannot move them." In passive hypnosis a challenge of this nature is best expressed in a clear and matter of fact voice, as a statement of fact. It is not an order or a command to the patient that he cannot move his legs; it it merely a statement of fact, that he has let himself go so completely that he cannot move his legs.

Patients in whom aggression is easily aroused, who are intolerant of authority, or who are so insecure that they react with anxiety at the slightest threat are often best allowed to drift into hypnotic sleep without any challenges at all; otherwise the patient may react with aggression or anxiety which will need alleviation before passive hypnosis can proceed.

Sometimes it is more convenient to proceed directly to the closure of the eyes. When ideas of heaviness and drowsiness

are first added to the suggestions of relaxation, it will be noted that some patients show a gradual narrowing of the palpebral fissures This is a sign that the patient is already being influenced, and it is also a good indication to concentrate suggestions on the patient's eye lids "Heavy and drowsy, legs are heavy, arms are heavy, it is all through you, eye-lids are heavy, the drowsy heaviness, so heavy they cannot stay open, they are weighed down with heaviness, heavy, stuck down with heaviness, so heavy you cannot open them"

In Braid's method, the patient fixes his gaze on some bright object such as a light, a shiny metal ball, a watch, or an ophthalmoscope lamp It is really the classical method for the induction of hypnosis It is extremely simple, and is undoubtedly a good method for those not very experienced in the induction of hypnosis But the introduction of mechanical aids of any sort has the effect of diverting the patient's awareness from the fact that he is doing it himself that he is voluntarily letting himself go into hypnosis

If fixation of gaze is desired it is considered that the direct stare is preferable to Braid's method The direct stare in which the patient looks directly into the therapist's eyes, is traditionally associated with authoritative hypnosis In fact the direct stare is probably the easiest way of dominating and overwhelming a patient in authoritative hypnosis On the other hand, the direct stare can be used in the passive induction The patient is told, 'Your eye lids are heavy, so heavy, you look at me, you let yourself go, you let yourself go completely, completely, and your body works automatically, your eyes are heavy, they close automatically, they are so heavy you cannot open them' In this method there is no question of the patient being overpowered by the withering stare of the therapist, it is rather a question of the patient fixing his gaze on the therapist's eyes and letting himself go abandoning himself

In using the direct stare in this way, it is important that rapport has already been established with the patient When used for authoritative hypnosis rapport is relatively unimportant, and the emphasis is on the prior establishment of prestige of the near omnipotent variety In the actual technique of the direct stare,

it is best for the therapist to look through the patient, as if he were focussing on some object at the back of the patient's head. The fact of the patient looking into the therapist's eyes undoubtedly has a symbolic effect which greatly enhances the suggestive processes. When the direct stare is used authoritatively, the symbolic effect seems to centre around deep-seated ideas concerning the folk-lore of the evil eye. However, when it is used passively, different symbolic factors come into play. An essential element in passive hypnosis is trust. Without trust the patient cannot relinquish his self-control to hypnosis. We can trust those who look us straight in the eye.

There is one important danger even in the passive use of the direct stare. Sometimes patients drift into hypnosis with the eyelids cataleptic in the widely open position. When this happens, the patient maintains an absolutely fixed stare. In this condition he can out-stare any therapist. This phenonemon is by no means uncommon, and it probably accounts for some of the well authenticated cases of the therapist having been hypnotized by the patient. When it occurs it is easily countered by closing the patient's eye-lids by drawing them down with the out-stretched index and middle fingers, and at the same time giving appropriate verbal suggestions. It will be found that the eyes remain closed, and the patient is quite deeply hypnotized.

The foregoing is intended as a guide to a therapist who has some experience of hypnosis before he proceeds to hypnography. It is in no way to be regarded as a comprehensive account of the induction of hypnosis by suggestions of relaxation. But some mention must be made as to the procedure in the event of the rejection of a suggestion. In the first place, patients are selected for this method of induction because they appear to accept suggestions of relaxation during the clinical test, at the first interview. As long as rapport is maintained, and the suggestions are not graded too steeply, there should be no question of the rejection of a suggestion. If such does occur, it is due to faulty technique on the part of the therapist. Nevertheless, in the event of such an occurrence, it is important that the therapist remain quietly calm. There is a tendency to anxiety on the part of the patient; and anxiety and aggression on the part of the therapist.

of relaxation with increased tension, are hypnotized by this technique.

During the initial part of the session, while the patient is allowed a little time to allay any transitory anxiety, the conversation centres around the idea of letting himself go, so that his body will work automatically. With the induction of hypnosis by suggestions of relaxation, the emphasis was on the "letting go"; in this case the emphasis is on the expectation of automatic movement. The patient sits at a desk or table, with the chair well drawn in, and a cushion at his back so that there is a tendency for him to lean forward over the table. The arms rest on the table, palms downwards, and the fingers apart. The patient is told to concentrate his gaze on his fingers. "Your eyes watch your fingers, you let yourself go, your eyes watch your fingers, everything lets go." If a certain amount of anxiety shows itself in increased muscle tension, it is no disadvantage in this method. Likewise, anything which is done which increases the air of expectancy is an aid in arm levitation. It is inevitable that one of the patient's fingers will give an involuntary twitch. The patient's attention is drawn to it. "Your finger moves, everything is letting go, another finger moves, it is coming, everything lets go. your fingers are light, so light they are lifting up off the table, lifting up, lifting up into the air." The suggestion of lightness and levitation may be repeated a number of times in different words. Some remark is always made on any movement. The patient's eyes are kept directed on his hands. It will soon be noticed that the gaze becomes quite fixed and staring, with the upper eye-lids well retracted. The hands lift slowly into the air, and the patient is hypnotized.

Suggestions of drowsiness and sleep are then given. The patient may slump forward with his head on the table, or he may be encouraged to support his head in his hands with his elbows on the table. He is given a rest in hypnotic sleep, and before waking is given the post-hypnotic suggestion for deeper hypnosis at the next session.

This method is simple, easy and direct. Its success depends very much on the proper selection of patients, those who show increasing tension when asked to relax. With other patients the

method may become laborious, and the suggestions may have to be repeated many times

With well selected cases there are very few difficulties When levitation is suggested, sometimes a patient will defend himself by falling forward and going to sleep In this case the suggestions are switched to relaxation Occasionally it will be noted that the patient actually pushes his arms down when suggestions of lightness are given This is a negativistic response, and a change of technique should immediately be made to induction by repetitive movements

It will sometimes be found that the hands are raised very promptly on the very first suggestion, whereas normally the arms are raised very slowly, and with a good deal of tremor and tension The eyes of these patients wander from their hands They do not have the fixed, staring gaze which always accompanies the induction of hypnosis by this method In fact they are not hypnotized at all At the last minute these people have changed their mind They are no longer prepared to abandon themselves to hypnosis They think that, if they voluntarily carry out all the suggestions, they will not be hypnotized as they are acting of their own accord Sometimes this defence is clearly conscious, other times it has the qualities of unconscious motivation The important thing is that the patient cannot avoid hypnosis in this way When the patient uses this defence, he is encouraged in his simulation The therapist must be careful to say or do nothing which would indicate to the patient that he has any doubts about the genuineness of the hypnosis The rather fantastic situation now develops in which the patient is feigning hypnosis, and at the same time the therapist is pretending that he believes the patient hypnotized This state of affairs is allowed to continue It is very important that good rapport is maintained It is really only rapport which prevents the patient from demonstrating to the therapist that he is not hypnotized At the slightest suggestion the arms are immediately raised or lowered The therapist must avoid challenging the patient in any way at all, or the patient will accept the challenge and simply put his hands down on the table The patient is dismissed without comment The same, apparently ridiculous, procedure is repeated the next session On

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the third session it will probably be noted that the patient's gaze is much more fixed and staring, and that his response to suggestions is slower. He has, in fact, become hypnotized, simply by being allowed to continue in his own simulation of hypnosis. He can now be challenged to put down his hands. Both agonist and antagonist muscles contract, and the arms remain unmoved. This first awareness on the part of the patient that he is in fact hypnotized may precipitate an acute but transitory anxiety reaction. The therapist must be ready to meet such an eventuality with suggestions of reassurance and calm, and allow the patient to rest in hypnotic sleep before waking.

4. HYPNOSIS BY THE INDUCTION OF REPETITIVE MOVEMENT

This technique is used with those patients who show negativistic behaviour. When one thing is suggested, they tend to do the opposite. Negativistic behaviour demonstrates that the patient is influenced in the opposite direction to what was intended. It is most clearly seen in the patient who pushes his hand down when he is given suggestions of lightness of the arm.

Negativistic behaviour of this nature is a defence. It is a psychological defence against the abandonment of the self to hypnosis. The important factor is that it is usually quite unconscious, and the patient is not aware that he is in fact doing the exact opposite of what is suggested to him.

These patients are easily hypnotized by the induction of repetitive movements of the arm. This may be done with the patient either lying down, or sitting at a table. The session is commenced with friendly casual talk about the patient letting himself go so that his body will work automatically. He is given some suggestions of ease and relaxation. He is then told, "I take your arm, it does not disturb you." So saying his forearm is raised by taking hold of the sleeve. The elbow remains resting on the couch, or table if the patient is seated. The forearm is balanced in a near perpendicular position. By the loose grip with which it is held by the sleeve, it is encouraged to flop about to either side of the vertical position. The patient is given the suggestions, "Everything lets go, your body works automatically, your arm goes back

and forth, back and forth, automatically, it goes back and forth automatically, it moves itself back and forth" When this is done with negativistic patients, it is found that the arm is pushed forward on the suggestion of backward movement, and pulled back on the suggestion of forward movement The suggestions are continued At first the movement of the arm is helped a little by pulling loosely on the sleeve Soon a back and forth movement is established although the direction of movement is the reverse of that suggested The sleeve is let go, and the movement persists The patient is told, 'Your arm moves to and fro automatically, you don't move it, it moves itself, it moves itself to and fro, and you can't stop it" The patient has been hypnotized by using his own defence against him

During the establishment of repetitive movement it is a considerable help if the suggestions are given slowly, monotonously, and in time with the movement of the arm At the start the rate of movement is controlled by holding the sleeve By this means the arm is encouraged to flop to either side of the vertical position, and in time with the droning verbal suggestions As the arm takes on spontaneous movement, the rate of speech may need to be modified so as to coincide with the rate of spontaneous movement of the arm which is not always the same as the rate of movement by pulling on the sleeve

It is almost always found that the patient spontaneously closes his eyes during this procedure There seems to be a general reluctance in the individual to observe hypnotic phenomena in the self On the other hand the observance of hypnotic phenomena in the self is a potent way of increasing the depth of hypnosis Accordingly, when the repetitive movement has been well established, and the patient challenged, he is then told, 'Your eyes open, you don't wake up from it, your arm goes to and fro, automatically to and fro, your eyes open, you don't wake up from it' The patient opens his eyes, and invariably looks away from the moving hand His gaze is directed to his hand, "Your eyes look at your hand, it goes to and fro automatically, your eyes look at your hand' The patient drifts deeper into hypnosis

There are very few complications of this method An occasional difficulty is that there does not seem to be sufficient tone

in the muscles to maintain the forearm in the vertical position. The sleeve is let go and the arm falls flaccid. This happens when the sleeve is let go too soon, before the repetitive movement has really become established. In this respect it is wise to let go the sleeve very slowly, so that contact is retained with the moving arm by just touching it with the finger, until it is absolutely sure that the movement is firmly established. The matter is also easier if the movement is set up around a well-balanced position of the forearm. When the patient is lying down, this is best attained with the elbow resting on the couch close by the patient's side, and the forearm near vertical and well everted, so that it is leaning somewhat outwards away from the body. If, in spite of these precautions, the arm falls by the patient's side, it is an easy matter to change to suggestions of relaxation. The lack of muscle tone in the arm is good evidence that suggestions of relaxation will be easily accepted.

5. THE DYNAMIC METHOD FOR THE INDUCTION OF HYPNOSIS

This is the method of inducing hypnosis in the more difficult patients. These are distinguished at the initial interview as patients who show no tendency to relax, nor do they show increased tension, nor evidence of negativism.

The theoretical basis for this method of hypnosis rests on suggestibility being regarded as a dynamic function of the psyche in contrast to the classical concept of suggestibility as a fairly fixed and rigid facet of the personality.

The classical explanation is that the difficulty in hypnotizing some patients is due to their lack of suggestibility. If suggestibility is considered as a dynamic function of the psyche, then this explanation is no longer valid. Moreover, if suggestibility is in fact a fluctuant, dynamic function, then anybody, who wants to, should be capable of being hypnotized by a technique which would modify suggestibility at the time of hypnosis. It is believed that patients, who want to be hypnotized, and who cannot be hypnotized, by the usually accepted methods, are prevented from going into hypnosis by unconscious defence mechanisms.

Passive hypnosis requires the voluntary abandonment of the

self, the abrogation of ego control It is believed that if this abandonment of control is interpreted as a threat to the ego, then unconscious psychological mechanisms come into operation to ward off the threat These mechanisms are of the nature of unconscious psychological defences and are not influenced by the patient's conscious desire to go into hypnosis

In general these unconscious defences against hypnosis fall into four main categories The first group consists of various expressions of restlessness The author used to think that this was a manifestation of anxiety evoked by the prospect of a new experience The restlessness may show itself in a great diversity of ways It is seen in its simplest form, when the patient is lying on the couch, and the first suggestions of relaxation are being given In these circumstances it is very common for the patient to exhibit varying degrees of restlessness Such patients fidget They cannot get comfortable They wriggle about on the couch They feel cold, and they want a blanket, or the blanket makes them hot, and they want it removed They often develop an irritation of the throat They start coughing although they have no sign of respiratory infection They want the handkerchief, just to touch the nose with it If the meaningful nature of this behaviour is not understood, it can be quite exasperating to the therapist Even more so when the patient develops the habit of asking needless questions Suggestions are being given, the patient seems to be relaxing, then he suddenly asks some pointless question He is completely alert again, the effect of the suggestions has been absolutely lost Another start is made only to be interrupted again in the same way

When the restlessness is described in these terms, it is clearly seen to be purposive in character It has the direct effect of warding off the onset of hypnosis The even more interesting fact about it is that it is motivated unconsciously From the oblique questioning of patients who are in good rapport, and who have showed this type of restlessness, it has become quite clear that the patient has no awareness of the purposive nature of his behaviour In fact, such patients desire to be hypnotized, and are consciously doing everything they can to allay their restlessness Viewed in this light it is seen that restlessness of

this nature is an unconsciously motivated psychological defence against the loss of control in hypnosis.

Sleep is another such defence. It sometimes occurs in its most dramatic form in patients with whom arm levitation is being attempted. The patient suddenly slumps forward on the table in a dead sleep. He has escaped from hypnosis into sleep. Defence by sleep also occurs in another way. Just as the therapist tries to turn the patient's defences against him in the process of hypnosis, in the same way, the patient will try to use suggestions given by the therapist as a defence against hypnosis. The suggestion of sleep lends itself to this. The therapist suggests sleep. The patient accepts the suggestion so literally, and so completely that he can use it as a defence. He has been told to go to sleep. He goes to sleep. When asleep you cannot hear anything. He does not hear any more suggestions. He has defended himself against hypnosis.

Other unconscious defences against hypnosis are negativism and simulation. These have already been described, but it is the unconscious nature of the motivation of this behaviour which is important to the present discussion.

From the foregoing, it is clear that suggestibility is not a mere fixed trait of the personality, but is a function of dynamic forces within the psyche. Unconscious mechanisms may intervene to save the ego from the threat of loss of control, and psychological defences operate to prevent the onset of hypnosis.

The dynamic method for the induction of hypnosis is a technique which utilizes these principles. Close observation discloses what defences are being used to prevent hypnosis. The suggestions are then altered accordingly, so as to circumvent the defences. Better still, the defences may be used against the patient by incorporating them in the hypnotic suggestions. The object is to keep the procedure fluctuant and dynamic. There is no monotonous repetition of the same suggestion. As in other techniques the suggestions are graded as to ease of acceptance, but in the dynamic method this is less important, and to some extent is replaced by continually changing the nature of the suggestions from one subject to another. The suggestions follow no fixed pattern, but are given according to the moment to moment situa-

tion with the patient It is essentially a technique of change Accordingly, the exact field in which the initial suggestions are made is unimportant, as in a few moments the suggestions will be switched to another area

The technique can perhaps be best explained by examples Rapport has been established, the patient is completely co-operative, and really desires to be hypnotized For a start the patient may be given suggestions of relaxation and drowsiness He wants to let himself relax and become drowsy Restlessness prevents his relaxing Unconscious defences are saving him from losing control The aim is now to use the defence in the hypnotic suggestions This can be done by changing from suggestions of relaxation to suggestions of movement Defence by restlessness cannot defend the patient against suggestions of movement It may be that he moves his hand He is told, "Your hand moves good, it is coming all through you, your fingers twitch, your hand moves again, it is all through you, your whole arm is light, you feel it, it is light, so light that it is lifting up into the air" In this way a change has been made from suggestions of relaxation to suggestions of levitation Against immobility the patient was defending himself with movement He is now given suggestions of movement A simple manoeuvre such as this will induce hypnosis in a great number of the more difficult patients But it may be that the patient still defends himself, and pushes down his hand when the suggestions of lightness are given In these circumstances he is told, "Everything lets go, your body works automatically, your arm goes back and forth, back and forth automatically" His arm is taken, and suggestions of repetitive movement are given Negativistic behaviour cannot defend him against suggestions of repetitive movement If defences are still active, he may let his arm fall down, relaxed and flaccid This obviously calls for suggestions of relaxation Sooner or later the defences give way, the suggestions are accepted, and the patient is hypnotized It is believed that practically anyone, who really wants to, can be hypnotized by this technique

It is a method which can be used with discretion Every time unconscious defences are recognized, it does not justify an immediate change to the dynamic method If the defences are

poorly developed, the original suggestions can be continued, and the weak defences peter out. Such is the case with a transitory restlessness which can be ignored. But as soon as the defences show any signs of persistence, then the suggestions should be changed to another area.

With the classical methods of induction, any change by the therapist was regarded as evidence of failure on his part. It is important that no remnants of this idea linger in the mind of the therapist using the dynamic technique. The inability of the patient to accept the original suggestions must not be interpreted as failure on the part of the therapist, nor must it be regarded as due to the perversity of the patient. It must be accepted, objectively and unemotionally, as the result of the operation of unconscious psychological mechanisms. As such, it is the signal to change the suggestions to another area.

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Chapter 4

DESCRIPTION OF HYPNOGRAPHY

The moving finger writes and having writ,
Moves on
OMAR KHAYYAM—FITZGERALD

1. THE TECHNIQUE

Before the hypnotic painting can be commenced, it is necessary that the patient attain a certain critical depth of hypnosis If this depth is not obtained, the patient will wake when he is given suggestions to paint The depth of hypnosis can never be accurately gauged by any single test, and there is no one test which is an infallible indication that the patient is deep enough for hypnography In spite of this, the induction of repetitive movements of the arm with the eyes open, and the persistence of the movement in face of challenges to stop it, is a very good guide in the matter As a general rule, it is unwise to attempt hypnography with anyone in whom automatic movements cannot be induced On the average, this depth is reached on the second or third session

It has been the practice not to have any prior discussion of the matter of painting with the patient The reason for this is that it was thought that, if the patient was told in advance that he was going to be asked to paint while under hypnosis, he could consciously elaborate ideas which might interfere with the spontaneous production of material in the painting It is not known whether this happens or not But the fact that there is no difference in character between the paintings of the first session and subsequent sessions might indicate that conscious elaboration is not an important factor

An interesting feature is that the sudden and unexpected presentation of the painting materials to the hypnotized patient, and the request to paint, does not evoke any sign of anxiety in

the patient. Whereas the waking, non-psychotic, patient under similar circumstances almost invariably reacts with initial anxiety. Furthermore, the waking patient usually refuses to paint, while the hypnotized subject on the other hand usually paints without much delay.

The patient is hypnotized sitting at a desk or table. Repetitive movement of the arm is induced with the eyes open, and the patient challenged. The movement is stopped, and the patient is put to sleep with a few appropriate suggestions. While the patient is asleep, the painting materials are brought in from an adjacent room, and placed in front of the patient. To ensure adequate depth, the repetitive movement is again induced, and stopped. The patient is then told, "Here is a paint brush, here is a paint book, I dip the brush in the paint, your hand takes the brush, it paints it, it paints it whatever it is."

These suggestions are given slowly and deliberately, if necessary they are repeated. The object is to get the patient to paint something which represents traumatic phychic material, either repressed material, or ideas of which he is aware but is unable to express verbally. The suggestions may be repeated in different words, but the non-specific nature of the suggestions is always maintained. "Your hand will paint it. Your hand will paint something. It paints what is in your mind. It paints it no matter what it is. It paints the things in your mind."

The patient usually takes the brush when it is handed to him. Many patients who have never been accustomed to drawing or painting take the brush and start painting without the slightest hesitation.

Some patients have trouble in getting started. Sometimes this is due to the very natural difficulty of the patient in adjusting himself to do something new and unexpected. The hypnotized patient actually experiences much less difficulty in adjusting himself to such a task than does the patient in the waking state. This difficulty is overcome by repeating the suggestions, and if necessary adding suggestions of ease and encouragement. Sometimes the trouble in getting started is due to blocking on account of the traumatic quality of the ideas seeking expression. In such cases the difficulty is met by emphasizing the idea of dissociation.

"Your hand will paint something," rather than, "You will paint something"

Characteristically, the brush is held very loosely It is inclined to flop about The impression is given that the patient is exercising no proper control over the movement of the brush In spite of appearances, the brush is actually controlled quite well. Some patients paint very slowly and the brush moves with tiny jerks as if emphasizing the automatic nature of the process Others paint at great speed There may be quite a manic quality about it One object is painted and the patient hurries on to the next which is often put in the corner of the same page It is enlarged, and soon overlaps the first painting The ideas seem to pour from his mind and there is a feverish haste to give them expression One object is not completed before proceeding to the next Paintings may be superimposed one on another To avoid this confusion, clean sheets of paper are placed in front of the patient, and as soon as one painting appears complete, it is withdrawn This procedure does not seem to disturb the patient or arrest the rapid flow of his ideas

Sometimes it appears that the patient would paint on and on indefinitely Sometimes the association between the different ideas expressed can be seen, more often there is no obvious connection between them

When the brush runs dry of paint, it is not uncommon for the patient to continue the action of painting with the dry brush The initiative required to dip the brush in the paint seems to be lacking This occurs with those who paint very slowly as well as with those who paint quickly Accordingly, when the brush is seen to be running dry, it is the custom to tell the patient "The brush is running out of paint, I take the brush and dip it in the paint" So saying, the brush is taken from the patient, dipped in the paint and returned to the patient This procedure has never roused the patient from hypnosis, and does not appear to interrupt his train of thought The patient invariably takes the brush and resumes painting This technique has proved more satisfactory than suggesting to the patient that he dip the brush in the paint himself This has usually resulted in the paint being spilt The painting is spoiled, and once the hypnotized patient

gets paint on his fingers, he is likely to soil his clothes and get paint on everything around him.

Another minor complication is that the painting often runs off the edge of the page and is continued on the top of the desk as if nothing has happened. Some patients habitually repeat the pattern of running off the paper. This type of behaviour often seems to have a symbolic significance. Frequently the original painting represents something unpleasant; then they proceed to paint something else a long way away from the unpleasant idea. To avoid danger from this contingency, a plastic cloth is placed over the desk. This minor difficulty takes a different form when starting a new painting book. The edge of a new book represents a drop of about a quarter of an inch to the surface of the desk. Under these circumstances when the brush has run off the edge of the page, occasionally the action of painting has been continued with the tip of the brush gliding along in the air just above the surface of the desk. When this happens the patient is told, "Your brush has run off the paper, I lift up your hand and put it back on the paper." The patient's hand which is holding the brush is lifted back on the paper, or a new piece of paper is substituted. Again, this procedure does not appear to disturb the patient.

As far as possible, care is taken to see that the patient does not smudge the painting. It is not uncommon for the patient to put his hand on the wet paint. Sometimes this is done in apparent oblivion of what he is doing; sometimes it is done in pointing to some particular part of the painting; but often when abreacting his emotion, the patient rubs his finger into the picture. or thumps it with his fist.

When the patient has expressed the idea which is seeking expression, the brush is often dropped or allowed to flop about aimlessly, and the painting may be spoiled. To avoid this, as soon as the patient appears to be finished, he is told, "I take the brush and put it down," and the brush is taken from him. Other patients when they have given expression to a particular idea, remain immobile and statuesque, starting at the painting with unblinking gaze; others go into a deep sleep and may slump forward on to the desk. Sometimes when the painting is finished,

the patient continues to paint over the outline again and again, apparently indefinitely, until the brush is taken from him

There is great variation in the amount of emotion displayed during the painting Some patients project highly traumatic material with very little outward show of emotion, others abreact with considerable violence Agitation and restlessness are common Some express their love or hate or aggression in words Some would destroy the object of their hate, or fondle the object of their love with symbolic gestures at the painting A loved object is caressed time and time again with the tip of the brush, sometimes with so much preoccupation that the projection of other ideas ceases The action continues until the brush is taken from the patient At other times the brush is bashed down on the paper to strike a hated figure A frequent form of abreaction is an unverbalized phonation of emotion

The main value of the hypnotic paintings in therapy lies in the patient's associations to the paintings The associations are obtained while the patient is still in the hypnotic state This seems quite important As a general rule, as long as the patient remains hypnotized, the potentially traumatic character of the ideas expressed in the painting, and verbalized in the associations does not disturb him

2 CONCLUDING THE SESSION

It is clear that the expression of suppressed and repressed material by painting under hypnosis involves a good deal of psychic stress Accordingly, it is thought wise to give the patient a rest after a series of paintings has been made He is told, "You won't wake up until I tell you, you see the easy chair, you stand up, you won't wake up, you go over to the chair, you flop down in the chair, you go deep asleep deep asleep, noises can't disturb you, you won't wake up until I tell you" The patient sometimes needs a little physical help in moving to the easy chair, but after the stress of the session, sleep comes easily with very little suggestion

Patients who are given a half-hour sleep after the session become calm and composed without any specific post hypnotic suggestions They are thus in a much better state to leave the

consulting room and return home. For medico-legal considerations rather than doubt as to the completeness of the patient's recovery from the hypnotic experience, it is the practice to insist that the patient be accompanied home by a relative or friend.

While the patient is asleep, the painting materials are removed from the room and the subject is not discussed unless the patient brings it up. This is to avoid anxiety between the treatments. At the beginning of the next session, the patient is given the opportunity to discuss the matters of the previous session.

Post-hypnotic suggestions of amnesia for the session are not usually given. It is ordinarily left to the patient to recall what material he is capable to bear, and repress the remainder. The degree of spontaneous amnesia varies from a complete blackout for the whole period of hypnosis, to a crystal clear memory of all the details of the painting and the accompanying subjective feelings. Most commonly there is a partial amnesia. The patient remembers what he has done in a general way, but remembers it only vaguely.

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Chapter 5

THE PAINTINGS

Th ngs done u thout example
Henr y VIII Act 1 Sc.2

1 GENERAL DESCRIPTION

The patient usually paints the outline of some object Superficially hypnotic paintings resemble the paintings of children They are poor representations of the objects which they aim to depict Outlines are irregular Symmetry is poorly preserved They often have the childish quality of not being properly placed in relation to the paper on which they are drawn They are commonly situated in the corner or at the edge of the paper leaving the central part of the page empty Not uncommonly the painting extends over the edge of the paper Ornamentation is absent There is no attempt to embellish the bare essentials The paintings are flat Nothing is done to give any idea of depth or perspective As with children s paintings they are often smudged or untidy Sexual conflicts are depicted with the uninhibited realism of childhood The body is shown in its nakedness and masculinity or femininity is emphasized by the size of genitals or breasts

These resemblances to childrens paintings suggest spontaneous age regression so that the patient may in fact be functioning at a childish level A difficulty in this explanation is that the childish appearance of the paintings is just as marked in paintings relating to the patient s adult life as it is in paintings of events in childhood However it is felt that even a gross inconsistancy such as this does not in itself rule out the possibility that age regression plays an important part Hypnosis is crowded with such anachronisms

On the other hand in spite of their superficial childishness there is a good deal to distinguish hypnotic paintings from the

paintings of children. A most important feature is that the poor likeness to the object of the hypnotic paintings is often purposive. This is motivated by the patient's desire to defend his ego. If the disclosure of psychic material in the painting is regarded by the patient as a threat to his ego, he defends himself against it. He depicts the conflict, but in such a way that it will not be recognized. On the other hand, the distortion of childrens' paintings is due to the technical ineptitude of the child, and lacks this purposive quality.

It must be remembered that most of the patients have no skill or aptitude at drawing. So, bearing in mind the purposive distortion of many of the paintings, it would seem that in many cases the paintings are as good as the patient could do in the waking state. With such patients it would seem that motor ability in this field is not much reduced by hypnosis.

The paintings show varying degrees of disorganization. Some patients habitually produce more disorganized paintings than others. It might be expected that the patient's natural abilities would play an important part. Strangely enough, this does not seem to be so. The few patients who had had some prior experience in drawing and painting did not use their skill in projecting their ideas in the hypnotic state. In fact their hypnotic paintings could not be distinguished from those who had no experience in painting. There is often great disorganization of the paintings when the patient is very deeply hypnotized. Motor ability which is usually not much reduced in moderate hypnosis, is often very considerably reduced in very deep hypnosis. During a session of, say, an hour and a half, during which the patient may make six or a dozen paintings, there is often a progressive increase in the depth of hypnosis. This is reflected in a scale of, increasing disorganization of the paintings.

Disorganization of the paintings is marked in another group of patients, those who are not very deeply hypnotized but who are projecting particularly traumatic psychic material. In these patients the disorganization is due to the defence mechanism already mentioned.

The hysterical element in hypnosis also plays its part in the disorganization of the paintings. The hypnotized subject tends

to behave in a way in which he believes a hypnotized person does behave If a patient believes that motor function is reduced in hypnosis, then he is likely to produce disorganized paintings The situation is further complicated by the phenomenon in which hypnotic manifestations occur to different degrees in dif ferent fields of ego activity Thus a patient may exhibit gross hysterical behaviour while under hypnosis, but the hysterical manifestations may not be carried into the field of the painting

Sometimes the execution of the painting simply does not keep up with the patient's ideation The ideas teem from his mind The painting cannot keep pace with them The drawing becomes more and more fragmentary and the disorganization may be such that the final product loses all resemblance to reality

Sometimes the disorganization of the painting may be increased by the patient writing or printing across it with the paint-brush Occasionally a start is made to depict some object and then the painting trails off into a written word, or the last syllable of a written word

Although the paintings are simple, direct, disorganized and child like, each patient has a style particularly his own, so that at a glance it is easy to name which patient has made a particular painting

On the other hand, the patient's normal personality traits may not show at all in his hypnotic paintings, especially if the paintings are made when the patient is in a very deeply hypnotized state Thus an obsessive patient in his normal state was characteristically neat, tidy and careful His handwriting was constricted and perfectionistic, with every detail of each letter exactly formed Yet this man's hypnotic paintings were free in the extreme and characteristically slip dash His writing sprawled all over the page in a manner quite the reverse of his normal way of doing things In contrast to this, other obsessive patients, who have been less deeply hypnotized, have shown obsessive characteristics in their hypnotic paintings in the way that might be expected

Figure 1. Hypnotic paintings are a poor likeness of the objects they aim to represent. A young girl, who works as a librarian, shows the rush of people coming to her with questions which she is unable to answer.

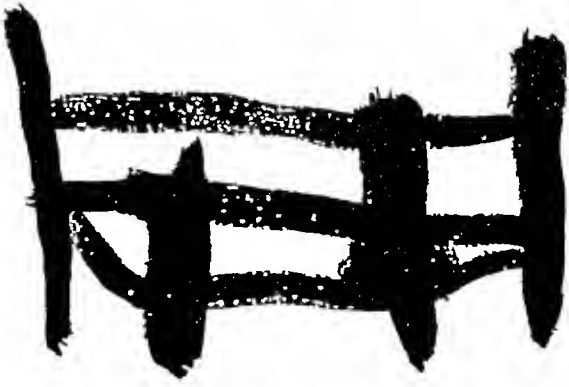

Figure 2. The poor likeness of the object does not depend on the patient's education or intelligence. A highly intelligent woman, a university graduate, draws this to represent a cot.

Figure 3 The hypnotic paintings often resemble the work of children

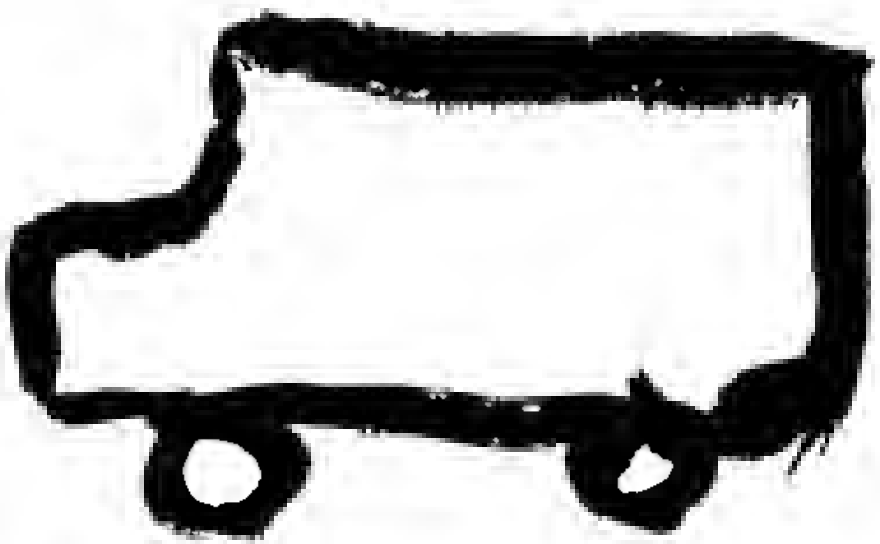

Figure 4 This is how a highly intelligent business man drew his new car It has the appearance of a child's drawing

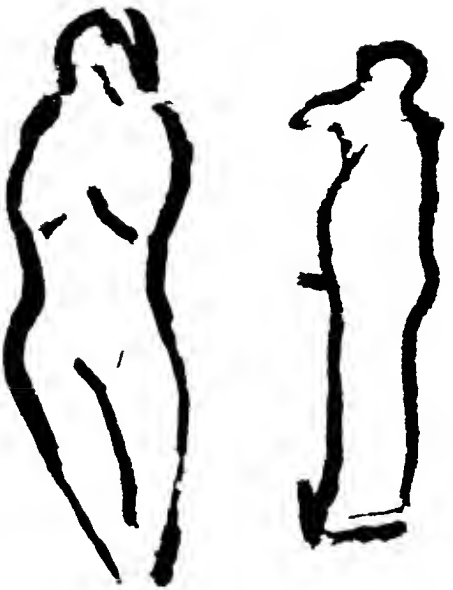

Figure 5. As with children, hypnotized patients often depict the genitalia in a quite uninhibited fashion.

Figure 6. The patient's artistic ability and experience in painting may not be displayed when he paints under hypnosis. This painting was made by a competent amateur artist. It shows the same degree of disorganization as the paintings of those who have never before painted.

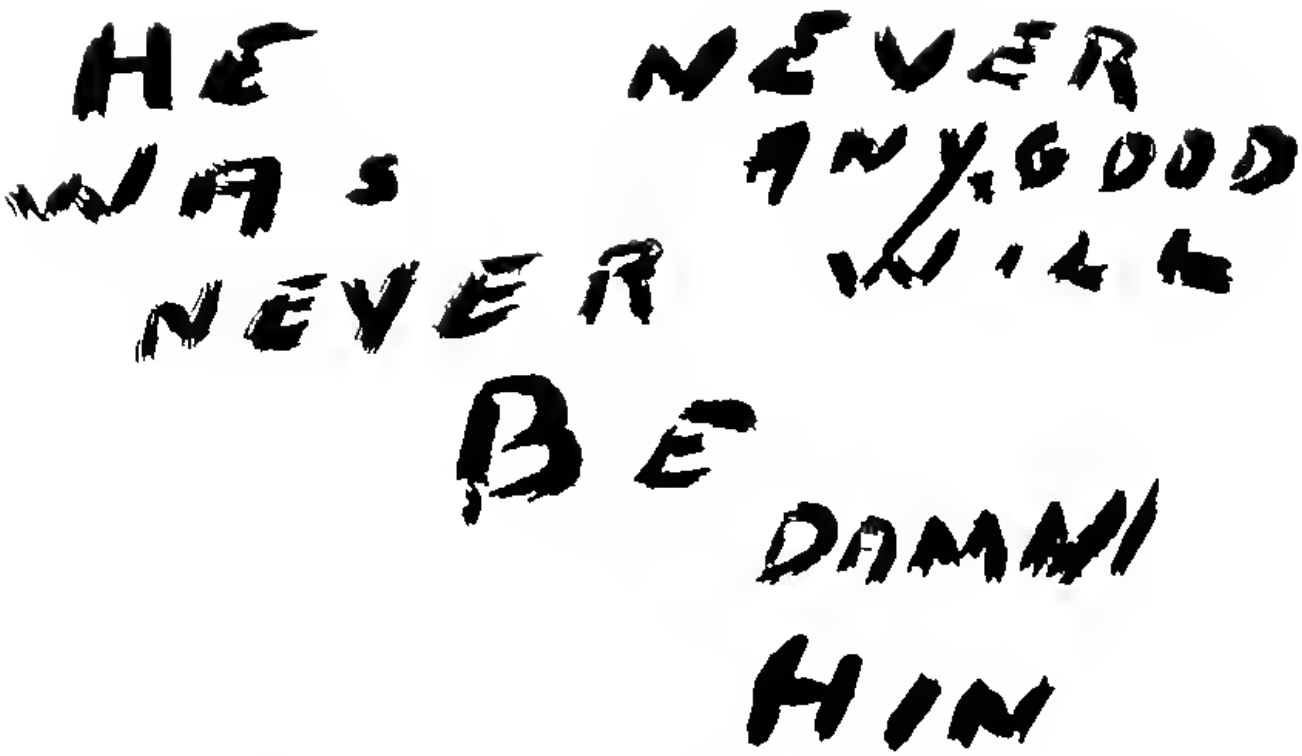

Figure 7 Sometimes patients express themselves in writing instead of painting The patient when a child heard his step brother say these words.

Figure 8 Just as in the waking drawings of psychotics the projections of hypnotized patients often show a mingling of pictorial and verbal material The woman who painted this, was extremely resentful of her husband being in the Navy She paints a ship and then writes the word navy across it

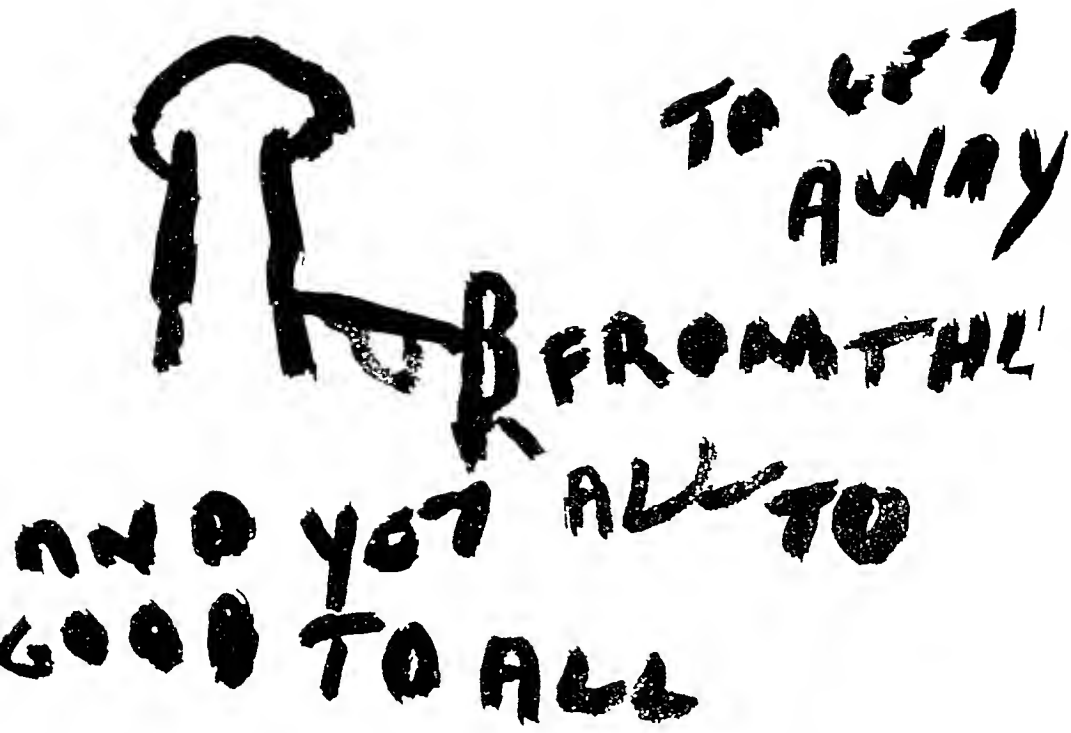

Figure 9. With greater depth of hypnosis, the paintings may become extremely disorganized. A farmer identifies his hopelessness with a dog chained to the trunk of a tree. This idea is contaminated by expressing a secondary idea by writing across the page.

Figure 10. As its neatness suggests, this painting was made by an obsessive patient. Sometimes the patient's normal personality is reflected in the hypnotic paintings, as in this case.

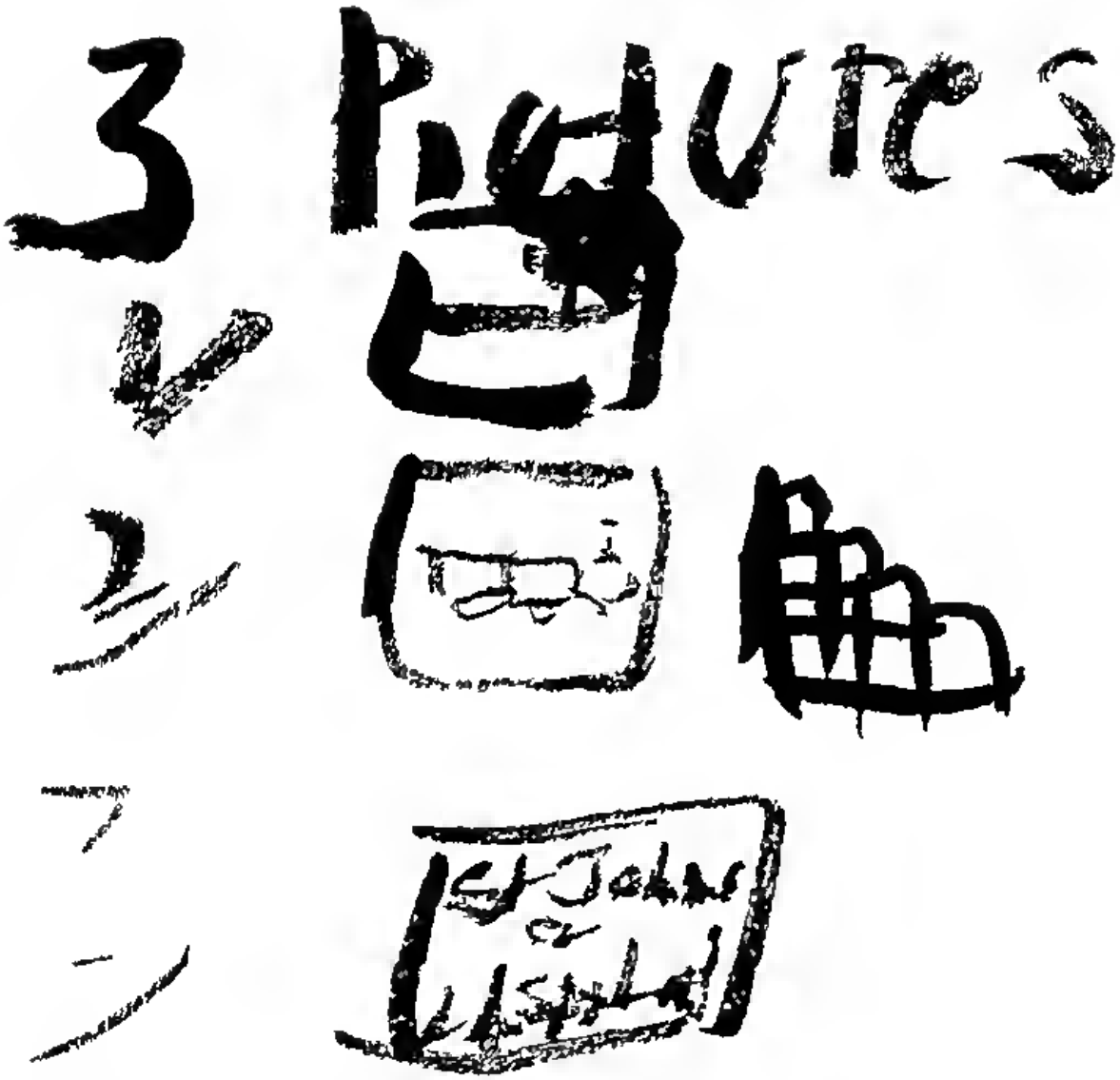

Figure 11 This painting was made by an obsessive patient, but the painting in no way reflects the obsessive characteristics of the patient's normal personality

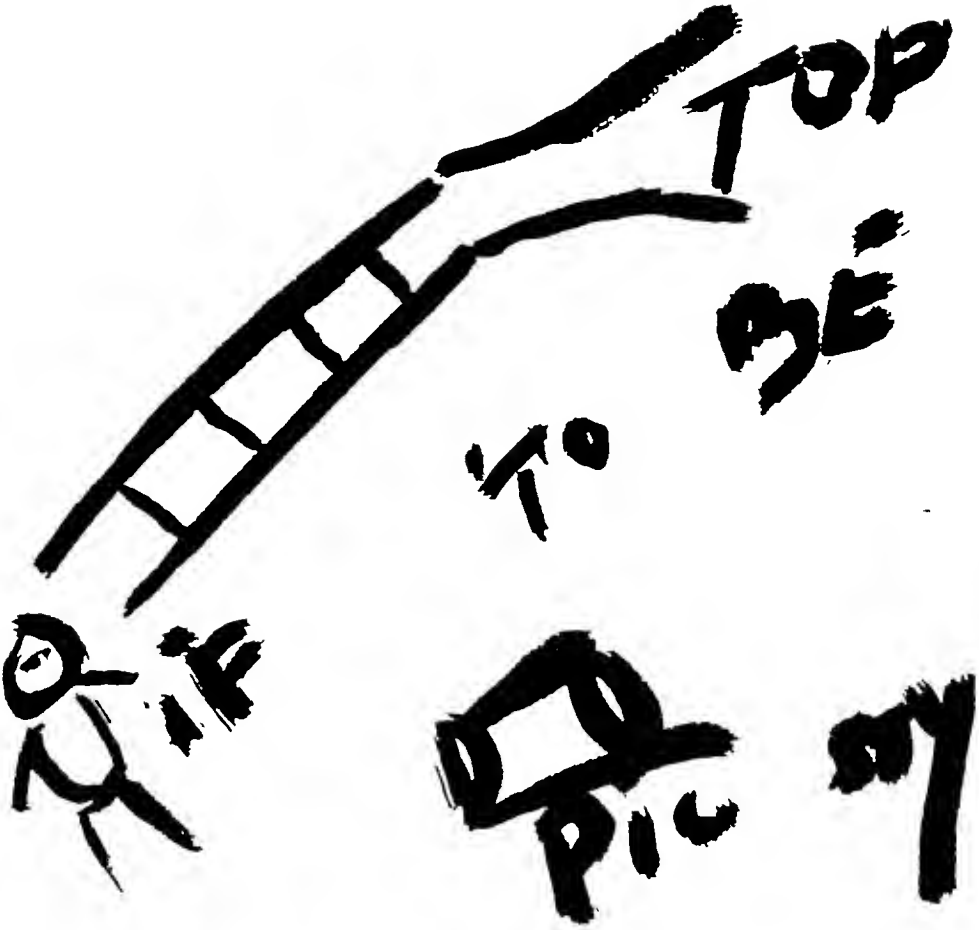

Figure 12. This painting was made by an obsessive patient, who normally writes with extreme neatness, and the construction of a characteristically perfectionistic style. In hypnosis he shows a freedom which is quite the antithesis of his normal personality.

2. THE SUBJECT MATTER

It is found that the object painted is in some way connected with an event which is psychically significant to the patient It is always some particular object which is painted, never a non specific, indefinite object It is not just a house, but it is the house where some specific incident took place It is not just a woman who is painted, but it is the particular woman who has been the object of his love or hate Sometimes when obtaining the associations the patient may at first defend himself by denying the specific nature of what he has painted He may say, "It is a house, just a house," or, 'A woman, just a woman' But if it is suggested that he can see it clearly, and can tell exactly what it is, he will disclose the real specific identity of what he has painted The waking subject when asked to paint, characteristically paints non specific objects Accordingly it is very easy to be misled into believing that the hypnotized patient has done likewise

Expression may be given to an event which took place at any time from infancy to the present day The infant's repressed memories of maternal rejection or the primal scene find expression Childhood loneliness and the search for sexual knowledge are common themes The paintings of patients in middle life often refer to conflicts and guilt, particularly sexual conflicts and sexual guilt of the period before marriage It would often seem that material of this nature had been suppressed rather than repressed Topics of the present day centre around biologically significant subjects, love and hate, mistress and lover

With the exception of the rare screen paintings, the subject represented is always something which is emotionally important to the individual When social, occupational or financial subjects occur, they often have a deeper significance as symbols of self realization Some themes that are particularly important to the individual, tend to be repeated in the same session, and may recur in subsequent sessions

Although a sexual content is very common in the paintings, the subject matter is by no means exclusively sexual Themes of self expression, of escape, of religious conflict are expressed

without apparent sexual significance. When hypnosis is lighter, everyday reality problems tend to appear.

Sometimes the subject is rather more abstract, and such concepts as the idea of going away, fear of growing old, and dread of homosexuality are given expression.

The subject matter of the paintings is quite unpredictable from knowledge of present day conflicts; it is also quite unpredictable from the content of previous paintings.

There is often a wide difference in time, place and emotional content in a series of successive paintings.

The subject matter is often far removed from the topics discussed in waking psychotherapy just prior to the induction of hypnosis. As an example; a young woman who had been under treatment for a few weeks for a chronic anxiety state, suffered an attempted rape two days prior to the session in question. Before she was hypnotized she related her experience with a good deal of distress. It was thought that in her painting she would project ideas of sex and violence, or at least something related to this potentially traumatic event. But instead she painted a complicated pattern which turned out to be the pattern on the kitchen linoleum when she was a child aged nine years. On one particular occasion when her mother was scolding her she had gazed very intently at the pattern on the floor.

When the painting relates to a present-day conflict, it is often found that the patient's attitude to the problem as shown by the painting or by his associations to the painting, is at marked variance to his attitude as disclosed in waking psychotherapy. Thus, a frigid patient, at the beginning of treatment, but after rapport had been established, made it clear that she was in no way frightened of becoming pregnant. She said she used contraceptives and had complete faith in their efficiency. Yet, in hypnosis, she expressed a very real fear of pregnancy. It would seem that intellectually she appreciated the safety of the contraceptives, but at a deeper psychic level coitus was still associated with pregnancy, and the idea was not really influenced by her intellectual considerations.

Another patient expressed a degree of hostility to his wife during hypnography, which was quite disproportionate to his

mildness during the waking state. It was thought that his attitude when awake, was determined, not so much by his loyalty to his wife, but rather by a defence to save his own ego from the disillusionment that his marriage was not a complete success.

With other patients, the subject matter of the painting may be related to the psychoneurosis symptomatically rather than aetiologically. The patient paints some object which is related to his symptoms. Thus a phobic patient painted a knife and an axe which were objects of phobic anxiety. It seems that this type of painting usually occurs with the less deeply hypnotized patients. As the production of symptomatic material is of no therapeutic value, it is an indication to use other techniques to increase the depth of hypnosis.

Some of the paintings are symbolic in the Freudian or Jungian sense. They must not be confused with the more common paintings which refer to specific traumatic incidents. Usually an understanding of the subject matter of a painting only comes through the patient's verbal associations.

Figure 13. The paintings commonly deal with basic human conflicts, with love and hate.

Figure 14. The conflict is often presented with stark realism. A man of forty ventilates repressed emotion concerning a homosexual assault when he was a child. He depicts the truck in which the assault took place, and his assailant on the right, with penis erect.

Figure 15 The *patient paints a woman s leg His associations make it clear* that it is not just a leg, but is the leg of a particular girl of his acquaintance

Figure 16. Sometimes the paintings represent a symptom of the neurosis rather than its cause. A girl suffering from writer's cramp wishes to sit for an examination. She paints the examination paper, and the clock indicating that time is running short.

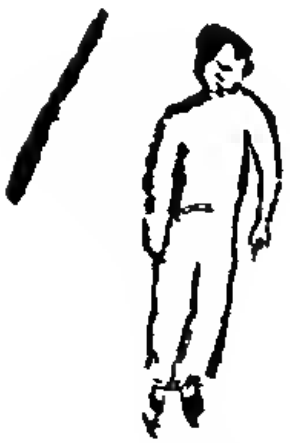

Figure 17. This symptomatic painting shows the patient's little boy, and the knife which she fears she will use to castrate him

Figure 18 The latent meaning of the painting may be much deeper than the manifest meaning An insecure and unsuccessful young man who plays competitive table-tennis paints the trophy He seeks recognition rather than the prize

Figure 19. The subject matter of the patient's paintings is quite unpredictable. Between two sessions of treatment a young woman suffered an attempt at rape. It was thought that her painting would show signs of sex and violence, but she painted the above pattern. Her associations disclosed that one day as a child, when she was being scolded by her mother, she kept looking at the floor. The painting represents the pattern of the kitchen linoleum when she was nine years old.

3. EMOTIONAL CONTENT

In general, the constant feature of the paintings is that they represent something which is psychically significant to the patient. Accordingly it is the emotional content rather than the factual content of the painting which is important. Actually the factual content may be quite unimportant.

Thus a woman discloses that some years ago her husband was unable to stop and talk with her on the day after her child was born. In terms of reality the matter would seem relatively unimportant. It is the type of experience which might be expected to be traumatic to a child, but not to an adult. Yet to the patient it was a matter of great emotional import.

Mention has been made of the different emotional reactions of patients while making the paintings. Some show violent abreaction; some show no emotional response whatever. It would seem that the degree of abreaction has little co-relation with the degree of emotional significance of the material projected in the painting. The ventilation of the emotion in abreaction is very much influenced by the personality structure of the patient, the depth of hypnosis, and the state of transference situation with the therapist, as well as the emotional significance of the material being projected. Thus the patient may disclose in the painting material which is highly charged emotionally, and at the same time preserve an air of detachment and emotional calm.

On the other hand, sometimes the emotion is seen clearly emphasized in the painting itself. The wicked thing is crossed out with a bold cross, the hated one is marked by vicious strokes from the brush, while the painting of the loved one is gone over gently with infinite care.

There is another aspect of the paintings which concerns the emotional content. Some conflicts are depicted statically, others are depicted dynamically. When the conflict concerns an event which may have involved considerable action, it may be expressed by painting some static object which was related to the action; or the participants of the action may be shown, but they are shown still and immobile. On the other hand, the traumatic event may be shown actually taking place. The action is all there. It is dynamic. It seems that the emotion is fully infused into the

painting Thus our patient might paint the outline of a man, and say, 'My husband, he beats me" Another woman might paint herself in the actual act of being beaten by her husband The difference in emotional significance of these two methods of expression is by no means clear It was at first thought that the more intelligent and more sophisticated patients would tend to express conflicts dynamically, and the duller and less sophisticated would tend to a static representation Experience with the Rorschach Test would lead one to anticipate some such grouping, but clinical experience with hypnotized patients does not confirm such a differentiation Furthermore, the emotional significance of the conflict to the patient does not seem to be the determining factor as to whether the event is depicted statically or dynamically, nor is there any constant relationship with the amount of abreaction at the time of making the painting

Most commonly, it is the primitive human emotions which are expressed in the paintings, stark love and hate, unadorned and undisguised But sometimes the content of the painting is in the nature of an abstraction, and then the accompanying emotion is more subtle and more complex Ideas of homosexuality, of loneliness, of going away are expressed with the appropriate emotion for the individual patient

Figure 21. The painting itself may not give any indication as to the amount of emotion involved in the production of the painting. A successful business man had travelled the world seeking treatment for depression. He resisted hypnotic painting with many defences over several sessions until he finally painted this figure. He gave the associations. "My nagging wife. Never stops harping." From then on he abreacted, and went on to make a complete symptomatic recovery.

Figure 22 This painting by another business executive would seem to express much more emotion than the previous illustration, but it elicited very similar associations My wife Can t get on Seem to be incompatible, always differences

Figure 23. Persons who have a particularly rich phantasy life may use the hypnotic painting to project their phantasies which are normally subject to vigorous suppression. The associations sometimes show the phantasies to be of a highly erotic, and often perverted, sexual nature.

Figure 24 The disproportion between the emotional significance and the factual importance of events is often illustrated in the paintings The patient gave these associations "Tripe They gave me tripe to eat If I had not had the tripe, they would have given me an anaesthetic The incident referred to the birth of her baby some years previously

Figure 25 It was at first thought that the more intelligent patients might express emotion by showing action in their paintings. This painting with so much movement was painted by a man of very superior intelligence

Figure 26. This painting of a running figure constrasts with the previous illustration in that it was done by a youth bordering on mental deficiency.

4. MANNER OF PRODUCTION

There is a good deal of variation in the way in which the paintings are made. The patient is given suggestions that he will paint something. The majority of patients take the brush and start painting without much delay. From the beginning their work with the brush is purposive. It seems that there is some image or phantasy in their mind, and when the suggestions are given they immediately go about the business of representing the image in painting. The first marks with the brush usually represent a salient feature of the completed painting. The painting may be made slowly or quickly, but it is clear that the patient is representing an image which is already in his mind. Any delay is due either to the technical difficulties of painting or to psychological defences, and is not due to any doubt as to what should be painted.

At the other extreme, there are other patients who go about the painting in quite a different way. When it is suggested that they paint something they take the brush and make a few tentative marks on the paper. The first marks that are made seem to be experimental, giving the impression that the patient wants to see the effect of the brush on the paper. The marks they make are

quite haphazard Odd, random marks may be made, and this may proceed to absent-minded doodling The suggestions that they will paint something are continued The patient makes more marks, still unstructured, meaningless marks Then, as the suggestions are continued, the patient starts to add to the marks he has made so that the random marks are structured into something with meaning This manner of painting lacks the purposive projection of images as seen in the former type In this latter type of painting, it seems that the unstructured matrix of tentative marks becomes the screen on to which ideas are projected This happens in much the same way as ideas are projected on to the ink-blots of the Rorschach Test With the painting the ideas are projected on to the amorphorous mass which is then structured to give the ideas expression In this process, sometimes traumatic conflicts which are seeking expression are projected through association with some shape in the unstructured material At other times, it seems that the random marks suggest sexual symbols to the patient, and the marks are then modified to give expression to some personal sexual experience of the patient It is interesting that when these random marks are given a sexual interpretation by the patient, it is always a specific sexual interpretation It is not just a penis or a breast, it is so and so's penis, or so and so's breast

Other patients paint in a manner analogous to automatic writing The patient is rigid, the gaze is fixed, and the brush is moved slowly The patient's behaviour suggests that he does not know what his hand is doing Dissociation is well marked, the patient being anxious to deny responsibility for the action of his hand

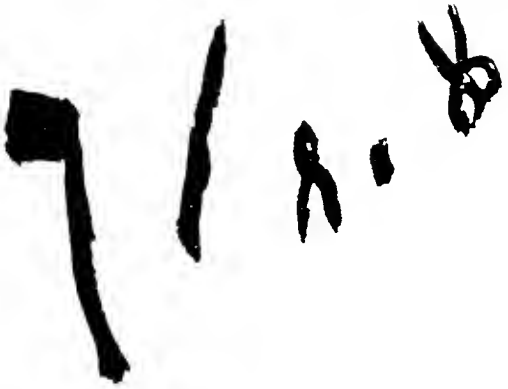

Figure 27. When the patient is asked to paint, it is often clear to the observer that the patient has something in his mind which he wants to express. The expression of the idea may be hindered by various defences, but the actual painting is purposive from the start.

The above symptomatic painting was made in this fashion. It represents the objects of the patient's anxiety, the axe, the carving knife, the secateurs, a razor blade, and the garden shears.

Figure 28 Sometimes the painting commences with the making of random, purposeless marks on the paper In this case the random marks were converted into a female figure It becomes some particular woman He identifies her by adding her initial, and verbalizes conflicts about her

Figure 29. Paintings that are made by structuring random marks into the shape of some object are always given a definite specificity in the associations. Haphazard brush marks were turned into a likeness of a big thighed woman. The patient names her as a woman of his acquaintance. Other marks are turned into a resemblance of the vulva, and again the patient names the woman.

Figure 30. It is a common procedure for patients to convert random marks into a painting with meaning. A similar mechanism may take place at a psychic level, in which case the process is a kind of rationalization. This is seen from this patient's associations. "Don't know. Looks like a W. Nothing. W. for wrong. I am worried. Can't work. Can't breathe properly. Just gasp."

Chapter 6

THE ASSOCIATIONS

Wonder and amazement inhabits here
The Tempest Act 5, Sc 1

1. METHOD OF OBTAINING THE ASSOCIATIONS

The main value of the hypnotic paintings in the treatment of the patient lies in the associations The patient gives verbal associations to the painting, and thus, indirectly, to the repressed conflict. Sometimes patients talk spontaneously They mutter their thoughts as they do the painting With other patients, the associations must be elicited from them

The most important thing about obtaining the associations is that the patient should remain in an adequate depth of hypnosis Very often the material projected in the painting is of an extremely traumatic character, and if presented to the patient in the waking state might easily evoke uncontrollable anxiety On the other hand, as long as the patient remains adequately hypnotized, it does not matter how traumatic the material, undue anxiety is not produced

It has been the custom to obtain the associations immediately after each painting is completed An exception is made in the case of the patient who rushes to express one idea after the other He is allowed to complete a series of paintings before his associations are obtained

The patient is given such suggestions as, "You won't wake up until I tell you, you can talk and you won't wake up. You talk in a dream and you don't wake up What is this that your hand has painted?" The suggestions can be repeated. If thought advisable, emphasis can be placed on the dissociation. "Your voice talks and you don't wake up" Alternatively the dream-like qualities of the situation can be stressed Patients almost invariably keep an unblinking gaze on the picture There is however a good

deal of variation in the way the associations are given. The voice may be quite clear and resemble the patient's ordinary speaking voice. More often it is a soft mumble which is difficult to hear. The ideas may be expressed fairly clearly and logically, with reasonable use of syntax. In other cases, the thought is rambling and incoherent. There is no attempt at logical expression. Unessential words are omitted. Speech may be reduced to nouns and verbs, with a few emotionally coloured adjectives. Other patients drawl out a whole series of associations and will continue for some time without any prompting from the therapist. The associations are almost always given slowly and with considerable pause between successive ideas. This has the happy result that it is usually quite easy to write down the associations verbatim in longhand. After some trial it was thought that the presence of a stenographer had a slight but definite inhibitory effect on the patient, so it was discontinued.

Sometimes there is difficulty in getting the hypnotized patient to speak. He may sit, just staring at the painting, quite unmoved by the suggestions that he may talk. There are two main causes of this state of affairs. Each requires rather different tactics on the part of the therapist. It seems that there is a good deal of individual variation with patients in the ease or difficulty with which they talk under hypnosis. Some speak spontaneously and freely, the first time hypnosis is induced. Others never talk freely, even in matters of no psychic importance, and they require continual prompting or they lapse into silence. Differences of this nature may be due to the patient's basic ideas about hypnosis. There is always the tendency of the hypnotized person to behave in a way which he believes a hypnotized person does behave. Under such circumstances a patient who believes that hypnosis is associated with sleep, or who believes that hypnotized persons do not speak, might find it hard to talk under hypnosis. These patients can be led into talking by a little patience on the part of the therapist.

With the other group of patients, the difficulty in talking is in the nature of a psychological defence. The patient is saving himself the hurt of awareness of the repressed material. The difficulty in talking is purposive, but because it is purposive, it only

obtains in psychically significant areas The patient refuses to talk about the painting, but can easily be led into talking about subjects which are suggested by the painting, but which are remote from the traumatic conflict Once the patient becomes accustomed to talking, he can be brought back to the central theme

When the patient has said something, and then lapses into silence, he can often be provoked into giving further associations by an interrogatory grunt on the part of the therapist In fact, such unverbalized queries as Umh," Eh," and 'Ah," are particularly useful in obtaining the associations They have the additional advantage in that they are in no way directive The patient is merely stimulated into expressing any idea which happens to be uppermost in his mind

2. THE NATURE OF THE ASSOCIATIONS

In the main, the ideas expressed in the associations are those of basic human conflict They are usually stark and unadorned There is no watering down of the expressions to make them more acceptable to the listener The ideas for the most part relate to biologically significant material, to love and hate, to guilt which is often sexual guilt, to striving for acceptance, and to doubt in the reality of God Feelings of loneliness and the essential isolation of the individual are common themes The period in time to which the associations refer is anything from the present day to childhood and infancy

A clothed female figure produces the association, 'My wife I hate her" An outline of two naked figures lying together with a shapeless blob between them is, Mum dad, me'

There is nothing vague about the associations They are blunt and realistic and to the point In this respect there is a marked difference from the usual associations of waking psychotherapy

Usually the patient's associations are isolated ideas, and are not connected together by any logical sequence, but are each evoked by the central theme of the painting Occasionally the associations tend more to resemble those of the waking state One idea leads to the next, and soon the thought is far away from the content of the painting It is the practice in such cases to bring the patient back to the painting from time to time, in the

belief that the idea contained in the painting is the psychically significant conflict. It is often possible to do this by merely pointing to the painting. When a patient has given a long series of associations, it is not uncommon for him to fall into a deep sleep. A patient who gives many associations on one occasion usually does likewise on other occasions.

The significance of the object depicted is often quite clear to the therapist, but sometimes the painting has no meaning at all without the patient's associations. This happens very commonly when the painting represents the place where some traumatic incident occurred.

Figure 31. Without the patient's associations it would often be impossible even to guess the meaning of the painting. A rather inhibited young man painted this. It represents his girl friend's breasts, as seen looking down the front of her dress.

Figure 32 Sometimes it is only the associations which give the painting any meaning at all A young male patient says of this painting 'Male and female sex organs Just together Just what I want, I suppose."

Figure 33 A woman in her early forties paints this, and gives the following associations. 'Me sitting in cupboard Mother put me in it. Think she dragged me by the wrists. *Fought against going Fight against it when people want me to do things.*"

Figure 34. The associations often show a persistent return to a main theme. A forty year old man seeking treatment for impotence, doodles under hypnosis, and then turns his doodling into a dog. He gives the association—"Dog—might be like (wife's) dog—So sad about it—Treated it like a little daughter—We got a dog—It upset me—(Wife) was fond of it, so fond of it because she did not have a child—My fault."

Figure 35. The associations often disclose quite a different attitude of mind to that shown in waking psychotherapy. A frigid woman was quite definite that she was not worried about the possibility of becoming pregnant. She used contraceptives and had complete faith in their efficiency. She added that it had never occurred to her to doubt the matter. Under hypnosis, she painted the word, "No," and gave the following associations. "No, I won't let him touch me while he is in the Navy. Then I do, and get pregnant, and get left on my own, so I say, 'No,' and 'No,' and 'No.'"

Figure 36 Sometimes the whole procedure has a dream-like quality about it, as in this patient's associations.

Patient—"Lot of things all mixed up together A square There is somebody watching I can see somebody is looking I'm standing on a square waiting for the rain to stop Somebody is watching me All at once it is fine Now I can go, but that "eye" is still on me"

Therapist—"How old are you?"

Patient—"Long long time ago I'm looking back, but there is no one there I can hear somebody coming and I am running It's going to be alright Can't see it any more Don't know who it was I am home now Mummy's saying, 'What's wrong?' I can't tell her It's alright She says it's alright, but I can still see it looking, looking at me"

3. THE EMOTIONAL ACCOMPANIMENT

There is a good deal of variation in the amount of emotion expressed during the giving of the associations The first association obtained is often the signal for a violent outburst of emotion It is common for a patient to make a painting in an air of detachment and apparent emotional serenity, and then, as soon as he

speaks a few words, there is an acute abreaction. The reason for this is not clear. It seems that many patients, who project traumatic material in painting without speaking, do so without abreaction, but as soon as it is suggested that they talk there is an outpouring of emotion, which may or may not be expressed in words. It is often shown in gesture, weeping and unverbalized phonation.

During the associations patients often act out the traumatic event; sometimes weeping in sadness or guilt, sometimes screaming in rage. On the other hand, some patients verbalize significant psychic material and the while maintain a fixed glassy stare and give no outward signs of emotion. Some have an air of abstraction about them. This might be so even with very traumatic events. There is no emotion at all. It would seem they are watching the event from a great way off. With others, the spontaneous muttering is accompanied by great emotion, and it is obvious that the patient is actually reliving the traumatic experience. The pattern of behaviour is constant with the individual patient and tends to be repated in subsequent sessions.

In relation to events in the past, particularly childhood experiences, sometimes the patient will appear to be describing the event as he witnesses it. He is there, but he is an onlooker. At other times the patient is actually reliving the incident and experiencing again all the emotion which went with it. Both mechanisms involve spontaneous regression, but the character of the regression is different in the two cases.

Chapter 7

PSYCHODYNAMICS OF HYPNOGRAPHY

To hold as twere the mirror up to nature
Hamlet Act 3 Sc 2

1 DEFENCES

The deeply hypnotized patient retains some ability to defend his ego If the disclosure of psychic material by painting is interpreted by the patient as a threat to his ego, then various defences are evoked

Failure to Hold the Brush Properly — The most commonly encountered defence is a reluctance on the part of the patient to hold the brush properly When given the brush, the patient holds it extremely loosely often taking hold of it with his finger tips by the extreme end of the handle The superficial appearance is that the brush is just flopping about without any control by the patient In spite of appearances the patient actually maintains quite good control Sometimes it would seem that the patient is anxious to demonstrate that he cannot hold the brush properly In reality, he is trying to turn the hypnotic situation into a defence The meaning of his behaviour is, "I am hypnotized You can see that a hypnotized person can t paint"

Sometimes the failure to hold the brush properly is complicated by the apparently hysterical behaviour which is not infrequently encountered in hypnosis The brush may be held in an odd manner between the thumb and little finger, instead of between the thumb and forefinger In spite of the patient's seeming disregard, the brush is really controlled quite purposefully When this type of behaviour was first encountered, it was thought that the patient was not properly hypnotized, and that he was merely acting On further study, it has become clear that this is not so Even deeply hypnotized patients may behave in this fashion, and the

apparently hysterical nature of their behaviour is in reality a defence against the threat of disclosure of their unconscious material through painting.

Some patients use the hypnotic situation as a defence in another way. It is not uncommon for the hypnotized patient to let his painting run off the edge of the page. When this is done habitually, it becomes a defence. There is a purposive element in it. The behaviour can be interpreted to mean, "I am hypnotized, a hypnotized person does not paint properly; he paints all over the place." By so doing, he defends himself against the disclosure of traumatic psychic material.

These defences are not particularly effective, and are satisfactorily combatted by merely suggesting to the patient that he take a proper hold of the brush and paint on the paper.

Sleep — Another common defence is going to sleep. This is likewise a matter of turning the hypnotic suggestions against the therapist. It usually occurs when hypnosis is induced by suggestions of relaxation, and particularly if the suggestion of drowsiness or sleep has been given or implied. At the suggestion that the patient will paint something, he simply slumps forward, his head on the table, in a deep sleep. Sometimes this defence comes into play when the patient has been hypnotized by an active method and the idea of sleep or drowsiness has never been mentioned. It seems that, in the minds of some patients, the concept of hypnosis is equated with sleep; such an idea undoubtedly facilitates the use of sleep as a defence.

It is an escape into sleep. It is a neat defence because it uses the therapist's own suggestions. The patient's attitude is, "You have told me I am relaxed. You can see that I am. I am so relaxed I am asleep. I can't paint."

The defence is countered by hypnotizing the patient by an active method such as arm levitation, in which the eyes remain open all the time. If necessary, suggestions can be added, "Your eyes are open, you are not asleep, you are quite awake, you are just letting yourself go."

When asked to paint, patients sometimes defend themselves by closing their eyes, as distinct from going to sleep. This is usually a half-hearted defence; at times perhaps it is more in the nature

of a protest, for a patient in reasonably deep hypnosis may still be able to find indirect means of expressing pintest There is never any difficulty in dealing with this defence A few suggestions to the patient that his eyes are opening and that they are looking at the paint-brush are sufficient to prepare him for painting

In a modification of this defence, the patient's eyes remain open, but he refuses to look at the paint-brush which he is holding in his hand This represents an attempt on the part of the patient to dissociate himself from the painting It occurs more often when the patient has been given suggestions involving some dissociation—'Your hand will paint something"—rather than—'You will paint something" With a few appropriate suggestions the patient looks at what he is doing, and the painting proceeds

Waking — The term "waking up," is used to denote a return from the hypnotic state to the normal waking state of consciousness It does not infer that the patient has been asleep A hypnotized patient ordinarily wakes up when he is given suggestions that are not sufficiently graded, when a too rapid transition is made from suggestions that are easy to accept, to suggestions that are difficult to accept A similar situation arises when the patient is inadequately prepared for hypnotic painting and the suggestion to paint comes as too great a step from previous suggestions If the material on the threshold of expression in the patient's mind, is particularly traumatic in quality, it adds to the effect of the too steeply graded suggestions, and the waking up becomes a defence By this means, the patient is saved from the expression of repressed or suppressed ideas

Most patients drift deeper into hypnosis as the painting proceeds, but an occasional patient becomes lighter during the session If such a patient becomes involved in the expression of traumatic material in his painting, he may waken The situation is met by repeating hypnotic suggestions at intervals during the painting, and so ensuring that an adequate depth of hypnosis is maintained The individual pattern of reaction in this matter appears to be constant If the patient becomes lighter during the painting on the first session, he tends to do likewise on successive occasions, so it is an easy matter to be forewarned, and take appropriate measures

Refusal to Paint — A direct refusal to paint is very uncommon; but occasionally a patient holds the brush immobile with his eyes steadily fixed on it, and makes no attempt to paint in spite of repeated suggestions. Once this defence is well established, a frontal attack by way of maintaining the suggestions for a long period is of no avail. On the other hand, the defence can usually be circumvented quite easily by emphasis on dissociation. Repetitive movements of the arm are induced with the eyes open, and the automatic nature of the movements is stressed. "You don't move your arm. It just moves itself." Then when it comes to painting, "Your hand paints it. Your hand paints it down itself." By this dissociation, the patient is allowed to refuse to paint; it is only his hand that does the painting.

One patient maintained his defence in refusing to paint in spite of repeated suggestions and in spite of emphasis on dissociation. It was then suggested he make marks on the paper with his brush—that is, unstructured meaningless marks, in contrast to painting something meaningful which was in his mind. He made the marks quite readily. He was soon brought around to structuring the meaningless marks into something with meaning, and significant psychic meaning to himself.

It seems that the patient does not defend himself against painting per se, but only against the psychic disclosures which the painting involves.

Camouflage — Even when the patient takes hold of the brush, fixes his attention on what he is doing, and starts to paint what is in his mind, he still may try to defend himslf from exposing his ego by trying to make what he paints unintelligible to the therapist. He paints some object that represents some significant psychic conflict, but he paints it in such a way as to be hardly recognizable. Sometimes this is done by leaving out parts of the picture so that it is fragmentary; sometimes the picture consists merely of an incomplete outline. Early in the study, it was thought that this phenomenon was due to the patient's reduced capabilities on account of the hypnotic state, but it is now realized that the failure to make a reasonable likeness of an object is often purposive, and is motivated by a desire not to disclose the meaning of what is painted. In other words, the patient has

obeyed the suggestion that he will take hold of the paint-brush and paint something which represents what is in his mind, but at the same time, he tries to defend his ego by making the painting meaningless to the therapist.

This is usually done by making only a very poor likeness of the object. There is often a childishness about it which suggests some degree of spontaneous hypnotic regression. This may happen even when the object depicted refers to a present day, as distinct from childhood conflict. Strangely enough, although the outline may be incomplete, the essentials are always presented, and its meaning is usually reasonably clear to the therapist.

In an effort to disguise the painting, patients will sometimes add to it after it has been finished. This procedure again has a childish quality about it, because the therapist watching the patient paint, sees what has been painted, and the subsequent camouflaging of it would appear pointless.

One patient drew an unmistakable likeness of the vulva. He then very carefully added a dot in the position of the clitoris. For some time he became preoccupied with this dot. He then became a little restless, and finally added a whole series of similar dots. It seemed that the only purpose in this was to disguise the significance of the first dot.

A further manifestation of the same process occurs when the patient depicts some psychically significant conflict and then suddenly paints it out. This has usually occurred in a fairly deeply hypnotized patient who has made the painting in a calm and apparently abstracted state of mind. It seems that the meaning of the painting suddenly dawns on him, and the whole is impulsively rubbed out and denied in a fit of emotion stirred up by the awareness of what he has done. The rubbing out is a denial that the awful thing ever happened. It is often accompanied by the abreaction of considerable emotion.

One female painted a male figure. While staring at the painting, she spontaneously verbalized her resentment towards her husband. Then she remained quiet for a few minutes, preoccupied with the painting. Suddenly, she seized the brush and roughly painted out the figure with heavy strokes, at the same time abreacting violently.

Denial — Even when a patient has made a satisfactory painting, he may still try to defend himself by not telling the therapist what it is. This usually happens when the patient, who is still hypnotized, is asked about the painting. The most common manifestation of this defence is for the patient to describe the painting in non-specific terms. For example, the patient may have painted the figure of a man. When asked about it he says, "A man." To further questioning the answer may still remain non-specific. "Just a man." In the early stages of these investigations, it was thought that some of these paintings were, in fact, non-specific. But with greater experience it is now believed that hypnotized persons hardly ever paint non-specific objects. If the painting is of a person, it is the mother, father, lover or hated one. It is never just a man or just a woman. If a house is painted, it is the house of childhood or the specific house where some specific traumatic incident occurred. Accordingly, when the patient gives non-specific associations, he is taxed further, "You can see it, who is it exactly?" The exact meaning of the painting has often been obvious to the therapist, but it is thought wise to persist with the patient's associations until he verbally acknowledges the meaning of what he has painted.

Sometimes, the denial is more complete, and the patient claims no knowledge of the picture at all. This usually occurs when the painting has been made under some pressure of dissociation, the patient having been told, "Your hand will paint it." The patient now uses the hypnotic suggestions as a defence. His attitude is, "My hand painted it, I know nothing about it." Once it has been possible to get a difficult patient to make one painting by means of emphasis on dissociation, it is usually fairly easy to get him to make subsequent paintings without suggestions of dissociation. Emphasis is now placed on the patient's freedom and his own responsibility. "You paint something that represents the thing in your mind. You paint it. You paint it yourself." The patient is thus denied the possibility of defending himself by lack of knowledge of the subject.

Occasionally, after making the painting, instead of denying knowledge of it, the patient refuses to talk at all. No response whatever is made to repeated questioning. The patient's reaction

seems to be, "It is too awful to talk about It is not to be talked about" Care is taken that adequate depth of hypnosis is maintained, and the patient is encouraged to talk about subjects peripheral to the main idea of the painting, and is later brought back to the central theme

Another form of defence by denial is a refusal to comprehend When painting is suggested, some patients take the brush in their hand quite readily, and make sweeping movements in the air above the paper, but without touching it At first, such gestures were interpreted to mean, 'I want to paint, but I don't know how" It was thought that these were people whose imagination was wanting, and who could not comprehend a way of expressing themselves graphically However, it has subsequently been observed that these patients resist the simplest suggestions in relation to painting, and it is now realized that a failure to comprehend can be used as a defence 'I know nothing about painting, I don't know what this is all about"

Screens — Early in the study of hypnotic paintings, when the patient referred to his painting in non specific terms, it was thought that the painting might be a form of screen painting analogous to the screen memory, which is occasionally produced in other forms of psychotherapy as a defence against the disclosure of traumatic material However, experience with the hypnotized patient has proved that screen paintings of this nature are very uncommon When they have occurred, and this has only been on rare occasions, in retrospect it has always been found that the patient was not so deeply hypnotized as had been thought It would seem that the hypnoidal or only lightly hypnotized patient on occasions may still mobilize psychological defences which enable him to produce screen paintings, which serve to protect him from the hurt of painting something with painful memories The screen painting is recognized by being better formed and less fragmented than the usual paintings, and by the patient's persistent non specific associations to the painting As screen paintings only occur in lightly hypnotized patients, they are more likely to occur as the first painting made by a patient, or at least as the first of a series at any particular

session. In this case there may be a marked difference in style between the first painting which is a screen-painting, and the subsequent true hypnotic paintings. The observation that screen-paintings only occur with the lightly hypnotized patient is consistent with experience in therapeutic painting with waking psychoneurotic patients who very commonly produce screen-paintings.

Factors Determining which Defence is Used — Besides the patient's personality structure and the nature of the repressed material, it would appear that there are other factors which are important in deciding which defence will be evoked by a particular patient on a particular occasion.

Different methods of induction tend to favour the production of different defences. Hypnosis by suggestions of relaxation is inclined to be followed by the use of sleep, closing the eyes, or motor inertia as a defence. Suggestions of dissociation on the other hand, lead the way to defence by denial. A too rapid transition from simpler suggestions to suggestions of painting, and a failure to maintain adequate depth of hypnosis during the session, make defence by waking so much the easier. Similarly, it seems that patients only defend themselves by screen-paintings when insufficient depth of hypnosis has been obtained.

The hypnotized person tends to behave in the way in which he believes a hypnotized person does behave. This phenomenon has a distinct bearing on the type of defence evoked. A patient who believes that the hypnotic state involves a loss of motor ability is likely to defend himself by refusing to paint, or by making only fragmentary paintings. The patient may harbour the idea that in hypnosis one does foolish things, or does things in a silly way. Such an idea may be elaborated into a defence by holding the paint-brush in an odd way. Many people believe that one goes to sleep when hypnotized. It seems probable that, when the opportunity arises, such patients would defend themselves by going to sleep.

Figure 37 When it was suggested to this patient that he would paint the thing in his mind, he defended himself by a direct refusal to paint It was then suggested that his hand would paint it, but his defence could not be circumvented by such suggestions of dissociation He refused to paint any thing at all for some time, until it was suggested that his hand would just make marks on the paper As this did not involve the disclosure of psychic material there was no need to defend himself against the suggestion, and he made these marks

Figure 38. This was done by the same patient who made the marks in the previous illustration. When he had been led into the way of freely painting marks on the paper, it was again suggested that he paint the thing in his mind. He then painted this facade of his factory, and at the same time ventilated conflicts concerning it.

Figure 39. The disorganization of the hypnotic paintings is often purposive. The patient fulfils the suggestion to paint what is in his mind, but at the same time defends himself in an attempt to make it unrecognizable. The painting refers to an incident when the patient was a boy at school. When using the toilet, he had been interrupted and teased by other boys.

Figure 40 This painting represents a ship, deliberately disorganized and camouflaged The defence breaks down because the meaning of the painting becomes clear from the patient's associations

Figure 41 A highly inhibited young man paints his fiancee s vulva He adds the dot in the mid line in the position of the clitoris For some time he is preoccupied with this dot He then suddenly adds the row of similar dots around the painting It appeared that during his preoccupation with the clitoral dot, hypnosis became rather lighter, and the other dots were added to camouflage the significance of the first dot

This type of defence by camouflage differs from that seen in the two previous illustrations. In them, the painting is camouflaged during the actual making of the painting It seems that the patient is aware of the idea which he is projecting and deliberately distorts the painting so that the idea which it contains will not be recognized Whereas in this painting the patient is unaware of the content of the painting, until it suddenly dawns on him, and then at this later stage he tries to camouflage it.

Figure 42. Although it was not definitely proved, this painting is probably another example of defence by camouflage. The patient first painted the central upright part of the painting which is now the body of the aeroplane. He became very preoccupied with this. From the patient's behaviour, it was thought to be a phallic symbol. After some time the wings were added and it was turned into a fighter aeroplane.

Figure 43 This painting is an example of defence by denial The patient painted the figure of a man whom she identified as her husband She abreacted considerable hostility towards him Then she tried to deny the whole thing by blotting out the painting

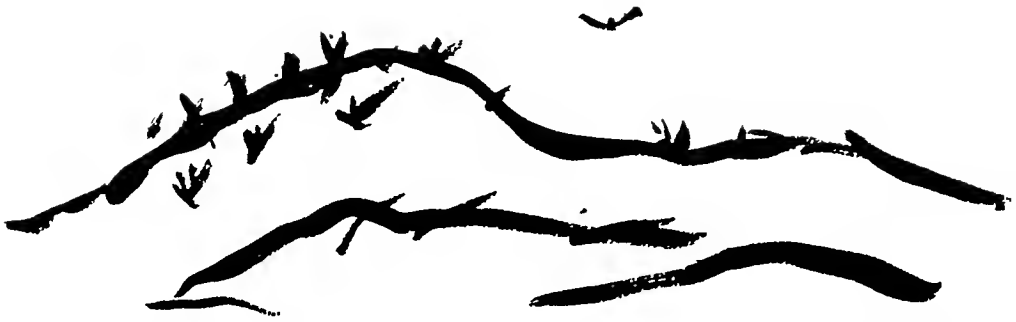

Figure 44. Screen-paintings have been found to be rare. In the lightly hypnotized patient they serve as a defence against the projection of painful conflicts. This screen-painting was intended as a landscape. The irrelevant painting of the bird would tend to identify the painting as a screen-painting in contrast to a painting of some place where some traumatic event had occurred.

Figure 45. This screen-painting was the first painting made by the patient. It is markedly different in character to the second painting, and all subsequent paintings done by the patient.

Figure 46 The next painting done by the patient who drew the rabbit was this gallows In retrospect it would appear that the patient was not sufficiently deeply hypnotized at the time she painted the rabbit

2 THE MEANING OF THE PATIENT S BEHAVIOUR

In our everyday life we express ourselves not only in words but also in our behaviour In hypnography the patient expresses himself graphically by painting something which represents his thoughts and he expresses himself verbally in his associations to the object which he has painted He also expresses himself in his behaviour while he is making the painting and giving his associations It has been seen how this process is incorporated with psychological defences which aim to save the patient the hurt of disclosing himself, but in addition to this it sometimes happens that the patient expresses his meaning in the way he does the painting rather than the painting itself

This mechanism applies particularly to the expression of sexual ideas. It seems that the concept of sexual intercourse is often intimately connected with ideas of rhythmical movement. In such a patient, if intercourse is the idea which is seeking expression in his hypnotized state, then instead of it being expressed directly in his painting, or his verbal associations to the painting, it may be expressed in his behaviour. His movements while making the painting take on a rhythmical motion. He keeps moving the brush back and forth. He may go over the same line, time and time again. The movement, at first jerky in character, becomes more and more rhythmical. The patient's pre-occupation with the movement becomes greater and greater. The action is continued although suggestions from the therapist cease. It is obvious that the patient is occupied in rich phantasy. The rhythmical movements at first only involve the brush, but they tend to spread. The patient's hand, and then his arm may develop regular swaying movements. Sometimes the rhythmicity seems to invade the whole body, and the sexual nature of the patient's pre-occupation is at once obvious. In other cases the sexual meaning of the behaviour is only disclosed by the patient's verbal associations.

This type of rhythmical behaviour which has a sexual significance usually results in the painting of some regular but meaningless pattern. In other cases, rhythmical behaviour is seen when the patient seems to fondle some loved object with the tip of the brush. Such an action may go on and on, apparently endlessly, until a halt is called by the active intervention of the therapist.

Emotion is often expressed more in the patient's behaviour than in the painting or the associations. The hate felt towards someone is expressed by the patient's behaviour in the roughness with which he paints the figure. The loved object, on the other hand, is painted gently, tenderly, lovingly, as if the brush were caressing it.

3. DIFFERENCES IN VERBAL AND GRAPHIC EXPRESSION

There are many psychological differences between the verbal expression of a conflict, and the expression of the same conflict in painting These differences are seen in the waking patient when painting is used as an adjunct to psychotherapy There are similar differences between the expression of conflicts in verbal hypno analysis and hypnography

The spoken word is essentially transitory It is of a mere moment's duration The only record it leaves is in the memory of those that hear it, and of all the functions of the mind there is none more subject to psychological distortion than memory Because of this, relatively simple defence mechanisms can deal with the verbally expressed conflict The spoken word is easily denied or forgotten Even in waking psychotherapy it is remarkable how often the patient develops an amnesia for the traumatic events which he has ventilated This process occurs much more readily with the hypnotized patient

On the other hand, anxiety in relation to a conflict expressed in painting cannot be so easily allayed by simple psychological defences There is a permanency about the painting It is there It cannot be denied or forgotten However, other defences are called into play, camouflage, or rubbing out Neither of these defences is as effective as forgetting the spoken word If denial is used, it can only be used in conjunction with dissociation 'It was my hand that painted it, not me'

When the material is expressed in painting the patient is actually confronted with the conflict It is there before him This, coupled with the relative *ineffectiveness* of the available psychological defences, makes anxiety reactions more common in hypnography than in verbal hypno analysis

There is another factor When a conflict is expressed in words, not only are the words transitory, but the actual time taken in the expression of the idea is very short With painting, the actual expression of the idea takes many hours This appears to have an effect on the patient It seems that the longer time taken to express the idea in painting gives it a better chance to become fixed in the patient's consciousness Thus an idea expressed in

hypnotic painting subsequently tends to persist in the patient's awareness even when the patient does not see the painting again.

There are other differences between verbal and graphic expression. Sometimes an idea which would be very hard to express in words, can be expressed very clearly in painting. This of course is a feature of great art, but the same principle often applies to the expression of a conflict in the painting of a hypnotized patient. This occurs particularly in the expression of abstract ideas. Words often fail to give meaning to an idea which can be expressed with a few strokes on the paper.

In painting, objects can easily be distorted. This distortion is accepted by those who look at the painting as a means of giving added meaning to the expression of the idea. Thus an unrealistic disparity in size of two human figures might greatly add to the meaning of a painting. There is no real equivalent of this in verbal expression. As soon as words are used to give the effect of distortion, there is a tendency for the listener to reject the idea either as exaggerated or mad. Poetic imagery may be an exception, but at the same time, the distortion of poetic metaphor is only accepted as giving added meaning when the reader is in a receptive state of mind. The fact remains that painting provides an easy and acceptable medium in which added meaning may be given by the process of distortion.

Both the spoken word and the painting are themselves symbols. Both can be used to express the more profound symbolism of Freudian or Jungian sense. As a general rule, this archaic symbolism is more easily expressed graphically than in words. Hence painting offers the patient a means of ventilating archaic material which may be seeking an outlet, but which could not find expression in words. This consideration is of significance as regards hypnography rather than waking psychotherapy. The non-psychotic patient does not often produce archaic material in ordinary psychotherapy, but in the hypnotized state it is different, the inhibitory forces are in abeyance, and it is not uncommon for archaic material to be given expression.

REFERENCE

MEARES, ANSLIE: (1955) The hypteroid aspects of hypnosis. *Am. J. Psychiat.*, *112*:11, 916.

Figure 47 Graphic expression allows added meaning to be given by distortion of the relative size of objects. The only field in which a very insecure foreign student can obtain recognition is in playing table-tennis. The huge bat gives him added power. The house on the right is home, where his family are awaiting his return

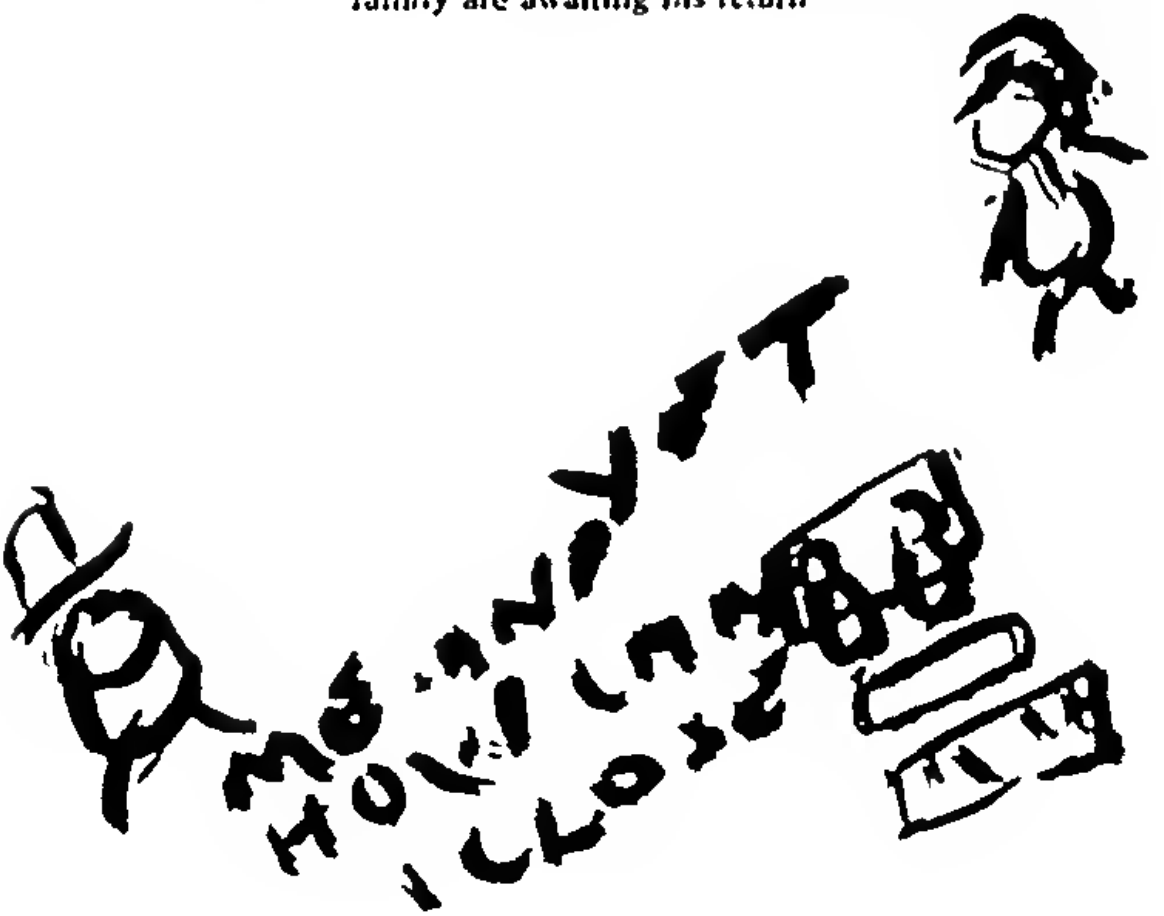

Figure 49. This painting is meant to represent a maze. The patient used it to express the complexity of a problem of theological doctrine with which he was preoccupied. The painting gives added meaning to his verbal description of the problem.

Figure 50. This remarkable painting depicts all the pathos of the patient's life. In the hypnotic state, she enigmatically described it as, "What I did, What I was, What I should have been."

The figures on the left are the patient and her lover. The central figure is the patient, distorted and ugly as the result of her extra-marital pregnancy. On the right is a bird, which she uses as a symbol of the pure life which should have been hers.

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Chapter 8

SYMBOLISM IN HYPNOGRAPHY

There is something in this more than natural,
If philosophy could find it out
Hamlet Act 2, Sc 2

An examination of the paintings shows that the hypnotized patient uses four distinct types or grades of symbolism. For convenience these will be called, representational, conventional, individual and universal symbols

1. REPRESENTATIONAL AND CONVENTIONAL SYMBOLS

Of the four types of symbolism, the representational symbol is the simplest. It is an attempt by the patient to paint a real likeness of some object. That the likeness refers to some particular object is often shown by including some distinctive peculiarity of the object in the painting. The specific nature of the symbol is thus shown in the painting itself without need of reference to the patient's associations. As a general rule, representational symbols do not occur very commonly in hypnotic painting. When they do occur, it is usually with the less deeply hypnotized patients. The subject matter of representational symbols is usually, but not invariably a present day conflict, rather than a traumatic incident of childhood. In subsequent sessions, with deeper hypnosis, the patient usually drifts into using conventional, individual or universal symbols.

The conventional symbol, as the name implies, is a means of expressing an idea by some conventional sign. A conventional symbol is based on a likeness to the object which it symbolizes; but the likeness has been so simplified, by the omission of all but the bare essentials, that its resemblance to reality is very much reduced. Thus a conventional symbol for the human figure is a stroke for the body surmounted by a rounded blob for the head

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and strokes for the arms and legs. In common with representational symbols, both the patient and the therapist know the general meaning of the conventional symbol. The specific meaning of the conventional symbol is only obtained from the patient's associations, whereas the specific meaning of the representational symbol is shown in some peculiarity of the painting. Thus a representational symbol of home has some likeness to the real home, but a common conventional symbol of home is a stylized drawing of a house, a rectangle with two squares for windows, a door in the centre, and smoke coming from the chimney. It must be remembered that the idea seeking expression in the hypnotic painting is usually expressed by painting some object related to the idea. A conventional symbol of a house may be painted to represent the patient's home; but the idea being ventilated by the symbolism is usually not "home," but is usually some specific incident which took place at home. This meaning only becomes clear from the patient's associations.

Conventional symbols, in one form or another, make up the great bulk of hypnotic paintings.

Figure 51. A business executive identifies himself with his place of employment. He paints the facade of the building. It is a representational symbol because it actually identifies the building by the three flags and the irregularity on the roof.

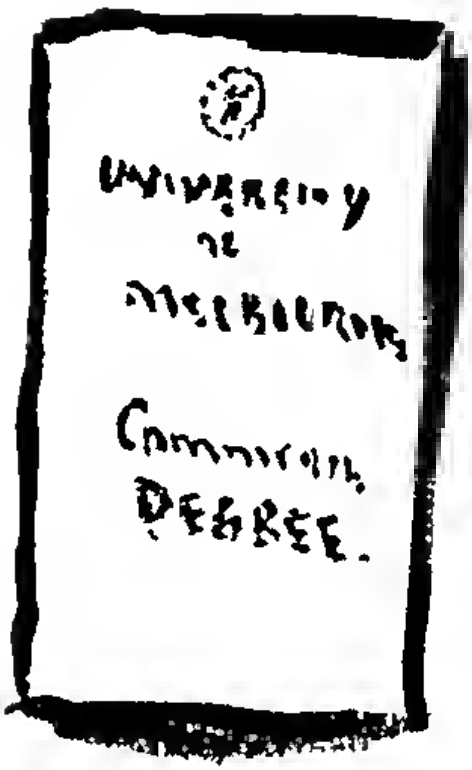

Figure 52. A university student paints a representational symbol It is the degree which is his immediate ambition

Figure 53. This is a conventional symbol of home. It has no likeness to the patient's home; but his associations showed clearly that it represented his home, where certain incidents took place.

Figure 54. In conventional symbols of the human figure there is nothing to identify the individual. But in the associations, the patient tells us exactly who they are.

Figure 55 A conventional symbol of a man, actually the patient's husband

Figure 56 Another conventional symbol

2. INDIVIDUAL SYMBOLS

Many patients make up symbols of their own They may represent quite commonplace objects such as the human figure, or they may relate to rather complex ideas which would be hard to represent in conventional symbolism A feature of the individual symbol is that the patient tends to use it repeatedly in different paintings and in different sessions The ability to invent and use individual symbols does not appear to be related to intelligence In a way the individual symbol is the personal property of the particular patient No two patients use the same individual symbol The patient always knows what it means, but unlike the representational and conventional symbol, the meaning is not known to the therapist until he learns it from the patient's associations Once the therapist has discovered the meaning in one painting, he knows the meaning when the symbol is repeated in subsequent paintings

It is interesting to note that individual symbols occur in the waking paintings of psychotic and pre psychotic patients They may only be recognized as such when they recur in several paintings, and the patient's associations to the paintings are obtained

Figure 57. This is a patient's individual symbol for a person. There is no resemblance at all to the human figure. It can only be identified as representing a person by the patient's associations. This symbol recurred many times in the patient's hypnotic paintings, and was always given the same meaning in the associations. It always represented some person, different persons on different occasions; but on each occasion always some specific individual. Without the patient's associations, the painting could easily be mistaken for a phallic symbol.

Figure 58. A female patient painted variations of this strange symbol many times. It is an individual symbol for the idea of going away. It really represents a path leading through a doorway; but without the patient's associations it would not be possible to deduce its meaning.

Figure 59 This is a modification of the patient's 'going away' symbol The painting represents her flat which was associated with very unpleasant memories The individual symbol for going away is added to this in the form of the heavy black line leading off the page

3 UNIVERSAL SYMBOLS

Hypnotic paintings may also contain universal symbols They are mostly the familiar phallic and female symbols In actual fact these universal symbols do not occur in hypnotic painting as frequently as might be expected It seems that the hypnotized patient does not have the same need as the waking patient to defend himself from awareness of sexual drives by the use of sexual symbols When hypnotized, the patient usually paints the genitalia realistically and undisguised, without having to protect himself by the use of universal symbolism

When it does occur, universal symbolism is usually the result

of fairly deep hypnosis. The therapist, from his knowledge of symbolism, knows the meaning. But as a general rule it has seemed that the patient, when he first paints a universal symbol, is not really fully aware of the meaning of the symbol. Although the patient may remain deeply hypnotized, it seems that the meaning only dawns on him after giving associations to what he has painted.

A young man painted a "U." On account of the shape and the patient's intense preoccupation with it, it was thought to be a universal symbol. When it came to getting the patient's associations, it seemed that he defended himself by giving what appeared to be screen associations. The patient then added a tail to the "U," so that it then looked like the small "u" of the printer. This was taken to be defence by camouflage. The patient's associations remained persistently vague. I then took my fountain pen and moved it in and out of the mouth of the "u." The patient immediately screamed out, "No, no," and showed all the signs of an acute anxiety reaction. He slumped forward. He was white and sweating. His breathing was rapid and shallow and the pulse racing. There seemed no doubt that a correct interpretation of this symbol had been made. The incident illustrates the fact that, even in his hypnotized state, the patient was not fully aware of the meaning of the symbol he had used.

Figure 60. This is a classical universal symbol for the female. It was made by a young man in deep hypnosis. He repeatedly gave what appeared to be screen associations, until I moved my fountain pen in and out of the mouth of the "U." He then screamed out, "No, no," and showed the signs of acute anxiety.

Figure 61 This extraordinary painting was done by a highly inhibited, middle aged single woman She was completely unsophisticated and had led an extremely sheltered and uneventful life save for a single sexual experience Her lover is represented with the snake The figure on the left is the patient Her associations made it clear that the appendage to the figure facing the snake is a magnified representation of her gaping vulva

Figure 62 *(Left)* A middle aged woman paints this to represent home Figure 63 *(Right)* In universal symbols the patient depicts the conception of her extramarital pregnancy The shapless blob at the lower left is the baby which she should have had

4. EVALUATION OF THE SYMBOLS

The greatest danger in the interpretation of the symbols in hypnotic painting lies in the possible confusion of individual and universal symbols. The individual symbol is essentially the creation of an individual to express some particular object or idea. It so happens that from appearances, some individual symbols are indistinguishable from universal symbols. They can only be distinguished by the patient's associations. Hence any attempt to understand hypnotic paintings from appearances, or by the arbitrary application of the principles of symbolism without resource to the associations, is likely to lead to false interpretations.

On the other hand the associations are usually quite clear and definite and leave no possible room for doubt as to whether the symbol is individual or universal.

The paintings abound with objects which would appear to be phallic or female symbols. The patient's associations usually prove these to be individual symbols, or poorly executed representations of objects, and without sexual significance.

It would be interesting to speculate as to the nature of the mechanisms which determine which type of symbolism will be used by the patient on a particular occasion. Nothing is known of this. Representational and conventional symbolism is usually the result of lighter hypnosis, and individual and universal symbolism is the result of deeper hypnosis, but there is no invariable rule.

As in waking psychotherapy, it sometimes seems that a symbol has different meanings at different levels of psychic integration. A patient drew the outline of a bed, and beside the bed, three objects like Indian clubs. It was thought that these might be phallic symbols; but the only associations obtained from the patient related to the three bottles of wine which she and her lover had drunk. The patient's conflict was clearly not in drinking the wine, but in the sexual experience which followed the wine. On these grounds it might seem that the symbols should be given a phallic interpretation. But it might just as well be that the bed was the patient's individual symbol for sex, and the bottles referred only to the wine. From the therapeutic point of view, the important idea projected was that the patient had been seduced.

The different possible interpretations of the details of the symbolism only came to notice on examining the painting after the session

Another patient gave indisputable evidence of the same symbol having different meanings at different levels of consciousness He repeatedly drew two figures joined together From his associations it was clear that sometimes the figures referred to a primal scene, his mother and father having intercourse, at other times it expressed the idea of homosexuality, of his unverbalized feeling of being both man and woman It is clear that the interpretation of symbols without further information from the patient is likely to be misleading This information from the patient is usually obtained by his verbal associations, but it may also be obtained by assessing the meaning of his behaviour while the paintings are being made

Figure 64 A feature of symbolism is that it somehow extracts and presents the essence of the idea concerned The marks on the left represent the husband He had been a successful soldier, but was completely unable to adjust himself in returning to civil life He is represented as a string of military ribbons among which the M C is conspicuous In words she ventilated her hostility about the over valuation of war records and decorations In the painting she has unconsciously expressed this idea by depicting the M C below the service ribbons when in her waking state she knew quite well that the M C. is worn in front of the service ribbons
On the right is the patient's individual symbol for going away By this she expresses the idea of going away from a husband who is no more than a row of military ribbons.

Figure 65. The symbol sometimes has a particular aptness. The patient was given six sleeping tablets and told to take two that night. Instead she took the whole six. In the hypnotic painting, the two tablets which she was allowed are represented as white, while the others are shown as black.

Figure 66. Both conventional and universal symbolism is shown in this painting.

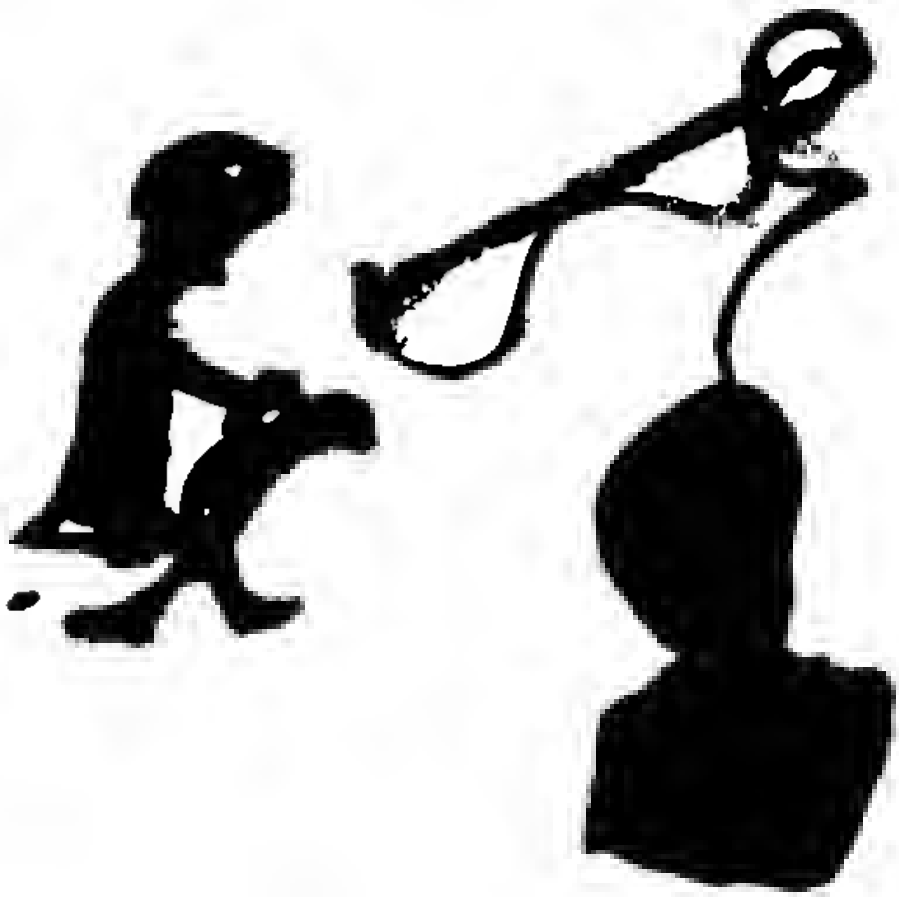

Figure 67 A middleaged patient, who lived with her mother, was suffering from a complete hysterical aphonia Psychotherapy was virtually impossible on account of her inability to communicate Attempts to restore her voice with waking suggestion had failed She was deeply hypnotized and in a long session, attempts with hypnotic suggestion also failed When tried with hypnography she produced this painting The figure on the left represents her mother scolding her as a child On the right the patient is being struck with the lash of her mother's tongue Her aphonia was a defence against her speaking rude things in retaliation against her mother Her voice returned during the session and she has remained well

Chapter 9

EXCERPTS FROM CASE HISTORIES

The heartache and the thousand natural shocks
That flesh is heir to
—Hamlet Act 3, Sc. 1

In order to give the reader a general idea of the material produced in hypnography, a series of hypnotic paintings of five patients is reproduced. With the paintings, the patient's verbal associations are recorded. These have been taken down verbatim, and represent every word the patient has said. It must be remembered that the associations have been elicited by non-directive enquiry on the part of the therapist. The patient is asked no direct questions beyond, "What is it?' or, "What is this that your hand has painted?" Other interrogation is quite non-specific, usually in the form of unverbalized grunts such as "Eh," "Umh," etc. In the few instances when the therapist has asked a more direct question it is recorded.

There is no attempt to present full case histories. Hypnography is merely one technique in the general psychotherapy of the patient; accordingly it is felt that full case histories would contain too much irrelevant material for a book which is primarily intended as a description of a special technique.

CASE HISTORY NO. 1

The patient is a farmer in his late thirties. He suffers from intractible insomnia of many years duration. When in hospital on various occasions for investigation and treatment, the night staff have consistently reported that the patient hardly sleeps at all even with very large quantities of paraldehyde or barbiturates. When he dozes in a half-sleep as a result of the sedatives, he is subject to terrifying dreams in which blood, meat and ideas of dismemberment form a prominent background. Over the years,

on different occasions he has become addicted to paraldehyde, chloralhydrate, and barbiturates. He is also subject to outbursts of impulsive violence in which some trivial mishap will provoke him into an uncontrollable rage in which he mercilessly beats the farm animals or strikes his wife. After the incident he is always sorry, ashamed and rather morose.

Clinically, he is tense and anxious, and discloses many obvious obsessive traits to his personality.

He has been given various forms of psychiatric treatment, superficial psychotherapy, deeper psychotherapy, E C T, continuous narcosis, narco-analysis, all without any significant effect

He is easily hypnotized, but attempts to relieve his insomnia by hypnotic suggestion have not been very successful

Since being treated with hypnography he has been less tense, the impulsive violence has ceased, but the insomnia has remained little improved.

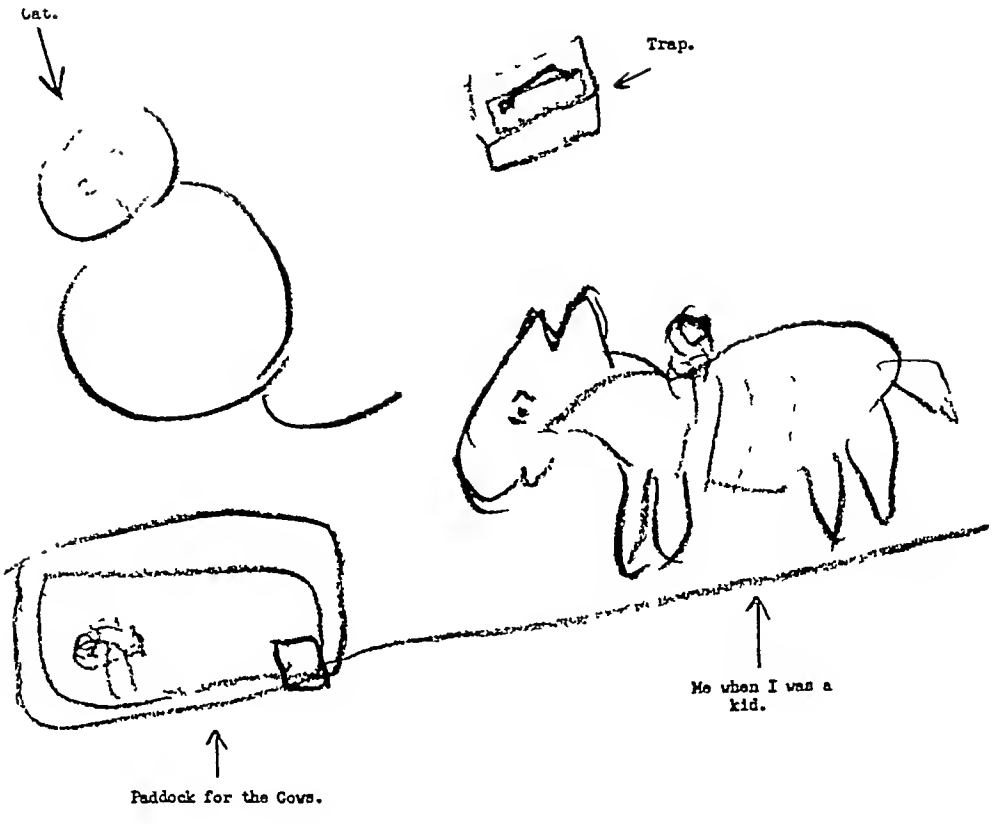

Figure 68

CASE NO. 1. *INTRACTIBLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Cat.
Trap.
Paddock for the cows.
Me, when I was a kid.

Comment—These drawings were done with soft lead pencil, before the advantages of using black paint had been realized.

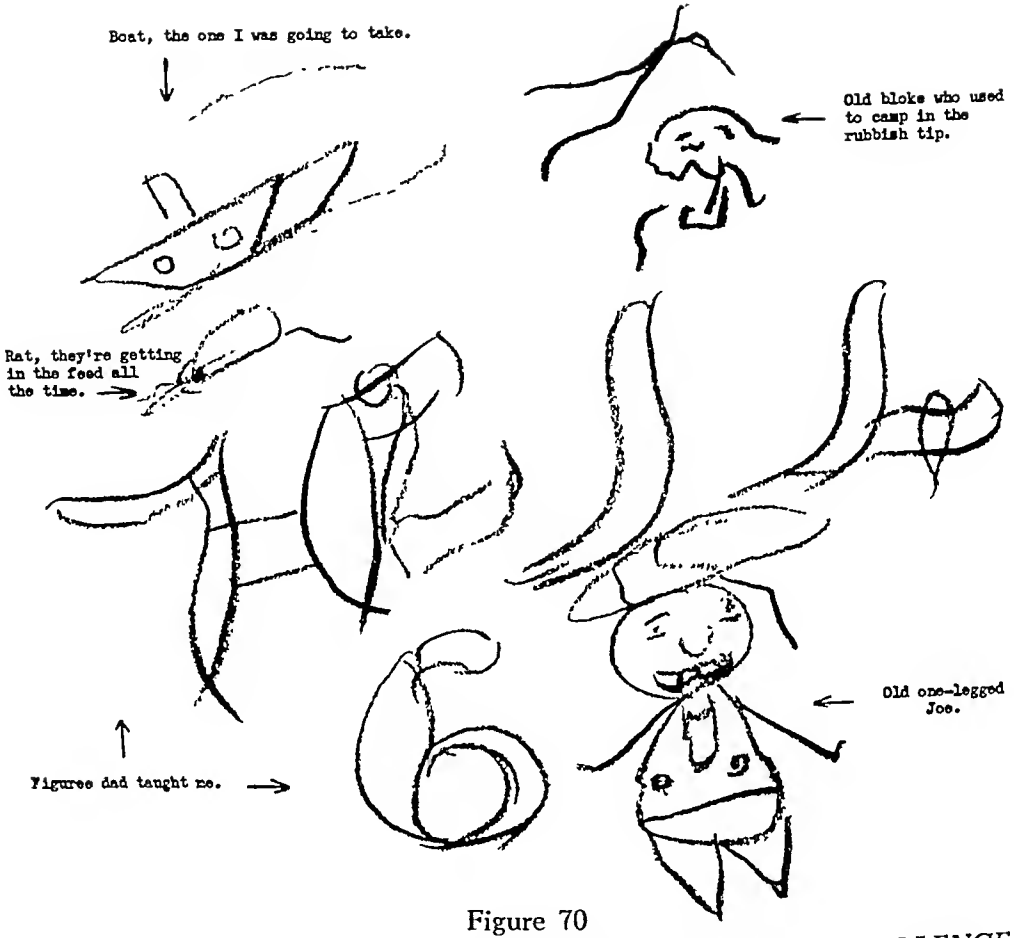

Figure 70

CASE NO. 1. *INTRACTIBLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Boat, the one I was going to take.
Old bloke who used to camp in the rubbish tip.
Rat, they're getting in the feed all the time.
Figures dad taught me.
Old one-legged Joe.

Comment—These drawings were done with soft lead pencil, before the advantages of using black paint had been realized.

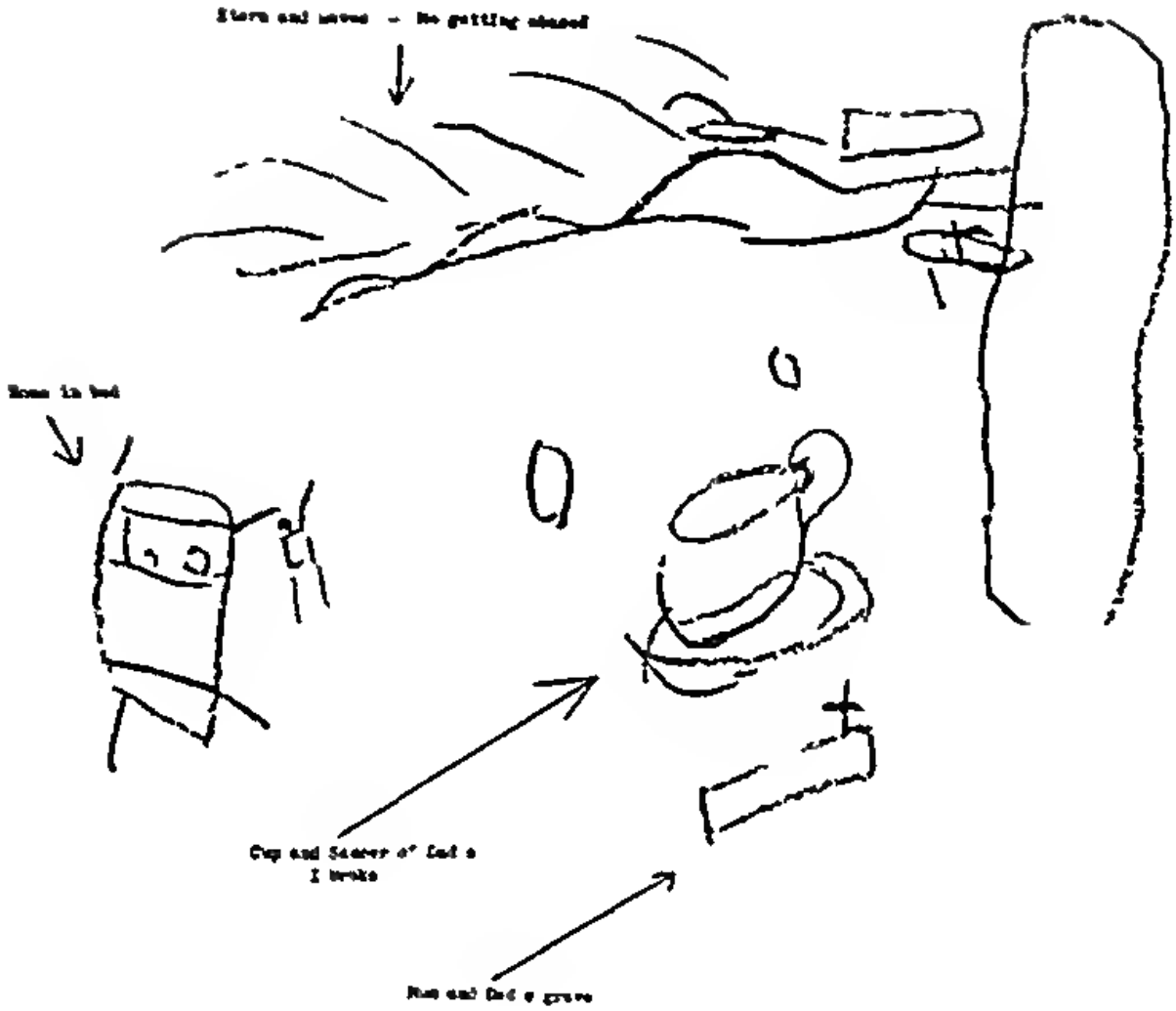

Figure 71

CASE NO 1. *INTRACTIBLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Storm and waves. Me getting chased
Home in bed
Cup and saucer of Dad's I broke.
Mum and Dad's grave

Comment—These drawings were done with soft lead pencil, before the advantages of using black paint had been realized.

Figure 72

CASE NO. 1. *INTRACTABLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Ship being tossed about.
The way things always seem to be.
Seem to be adrift in a boat or something.
Helpless.
Everything jumbled.
Seem to be swamped by yourself.
Everything seems to be a mistake.
Tried to avoid mistakes, but can't.
That is what it has been all the time.
Seem to be tossed by storm and rain.

Figure 73

CASE NO 1 *INTRACTABLE INSOMNIA IMPULSIVE VIOLENCE OBSFSSIVE PERSONALITY*

PATIENT S ASSOCIATIONS WHILE UNDER HYPNOSIS

This is a fence around the lake
Got into strife with mum one night
She helted me and I cleared off
Went off past the lake
Dad got hurt somehow felling a tree
While I was away my grandmother got killed she was taken to hospital and they needed help
These are willow trees by the lake
This is the brick kiln where I hid

Figure 74

CASE NO. 1. *INTRACTABLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

12,000 gallons of water have got to go from the windmill so that there will be ample to go down from two and three paddocks over to five and six.

The main supply from that mill.

Figure 75

CASE NO. 1. *INTRACTABLE INSOMNIA IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Sent out with young Jack when he was a baby
This is Jack here
I started playing with some kids, and the pram got out of control and went down the hill
I found him lying on his side with blood streaming out of his head
I thought I had killed him
That's Jack there
I got a belting again
Was frightened I had killed him
That hurt more than the hiding

Figure 76

CASE NO. 1. *INTRACTABLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Main drains we are putting through to take water to stop those trees dying.

Take the drains right across and save the cows getting foot rot.

This is a pipe about two foot six inches covered with gravel.

I won't get it finished before the weather gets bad.

Comment—Note the change from an incident in childhood, back to a present day reality problem, in successive paintings.

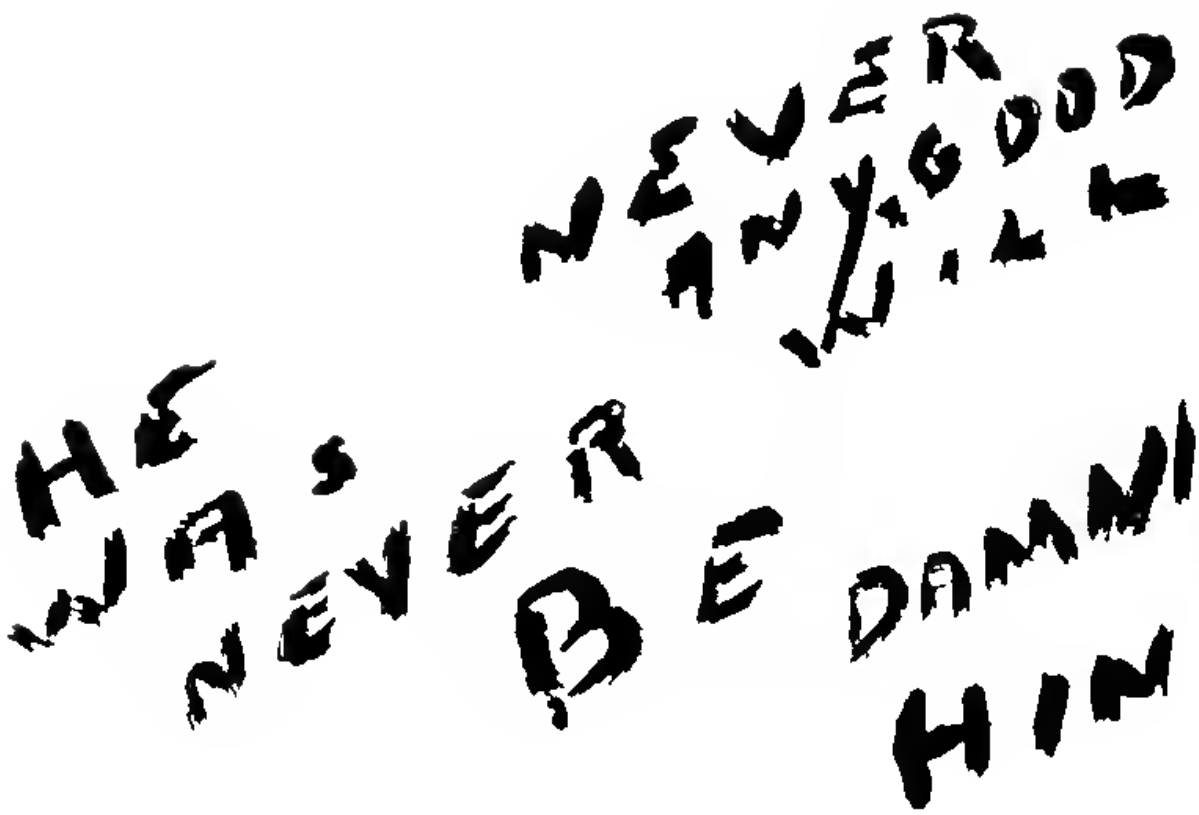

Figure 77

CASE NO 1 *INTRACTABLE INSOMNIA IMPULSIVE VIOLENCE OBSESSIVE PERSONALITY*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Something I have had said to me a couple of times
Mother was married twice
Children from the first marriage
Father was drowned in the (—) I think
Dad married
There was a boy about 4 years older than I was from that marriage
I used to always think he was my full brother
He knew I wasn't and that is what he kept saying to me
Also I remember that once I had a row with mum
Dad took my part and mum took his part
That is what he said to my father *(points to painting)*
I wonder now is he right Is it true

Figure 78

CASE NO. 1. *INTRACTABLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Bell of the church. Church over there.

The vicar's house there.

I used to ring the bell for communion, morning and evening services and Sunday school.

I was late one time in ringing it, and the minister went crook for ringing the first bell late.

After the services, I thought I would get my own back.

I tried to throw a stone at his house, but it went through one of the windows.

I knew it wasn't right, yet I was not game enough to go and tell him I had done it.

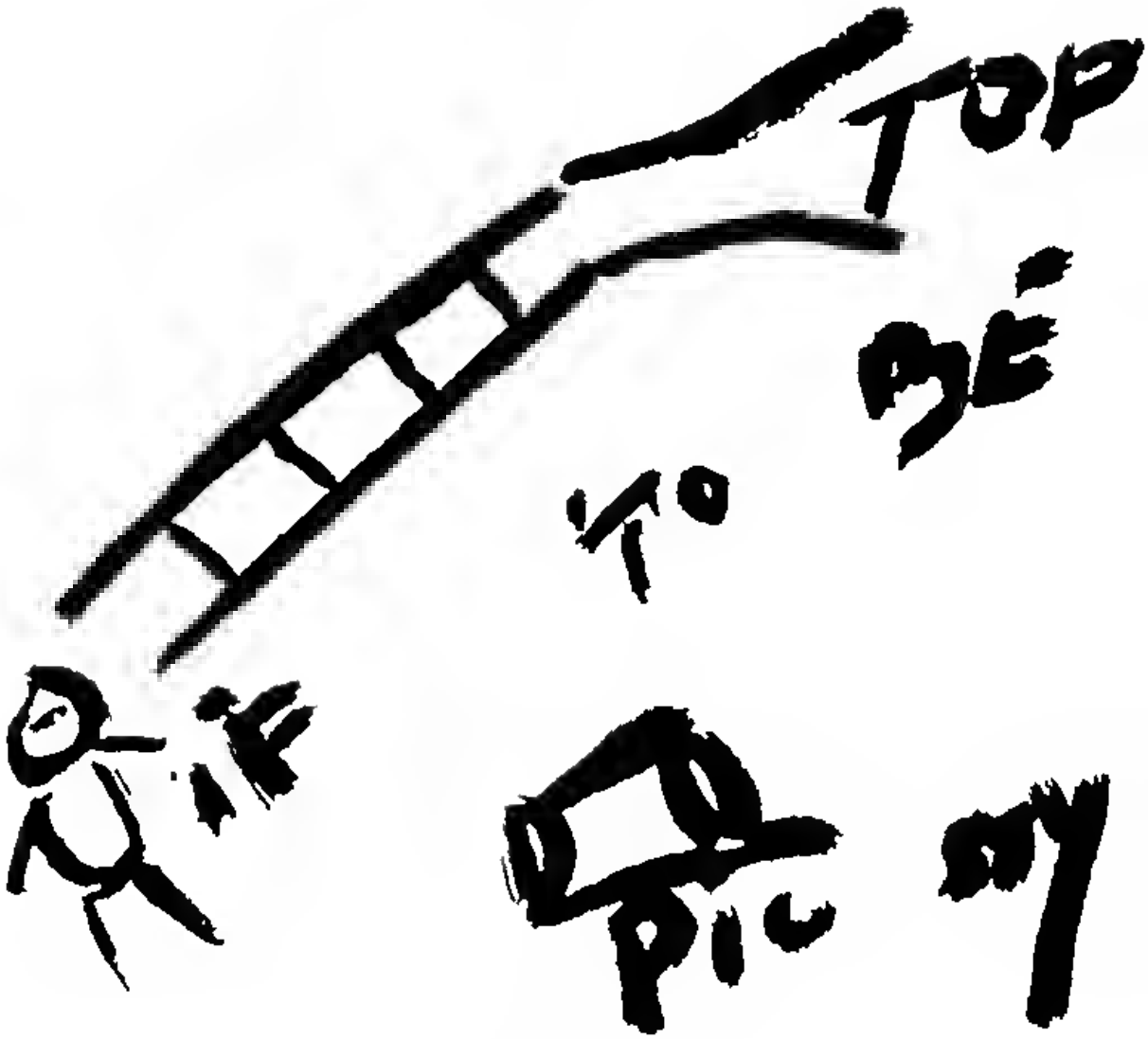

Figure 79

CASE NO 1 *INTRACTABLE INSOMNIA IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY*

PATIENT S ASSOCIATIONS WHILE UNDER HYPNOSIS

Ladder to the things of life
I can get to the bottom, but can't get any further up
Want to be on top
Other people are sure of themselves.
Full of assurance
Pig sty at home
Used to call me 'Piggy (—)"
I used to collect scraps for the pigs
Kids used to call me 'Piggy (—)'
Something I can't get above

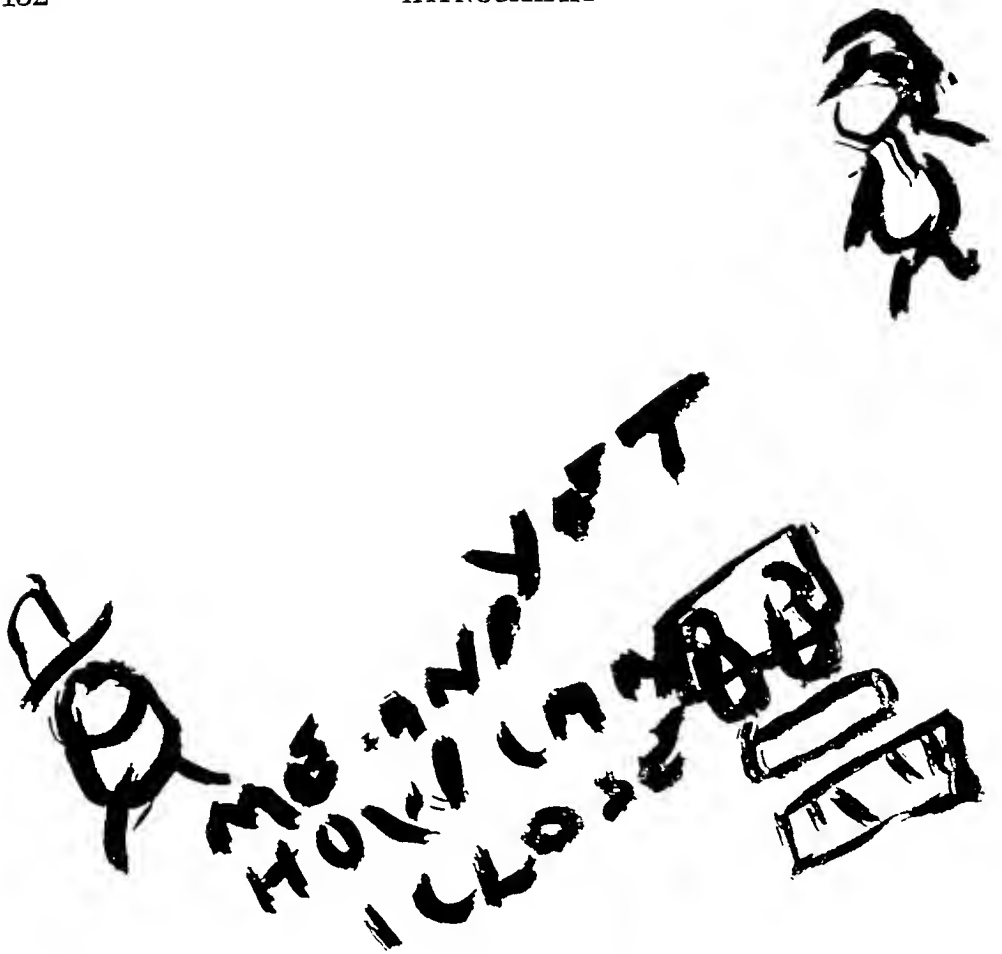

Figure 80

CASE NO. 1. *INTRACTABLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

This is (— wife's first name).

At (—), we used to be like this, always close together in thought, word, and deed.

So far apart.

Would like to get back like this.

Seems to be some barrier on my part that prevents it.

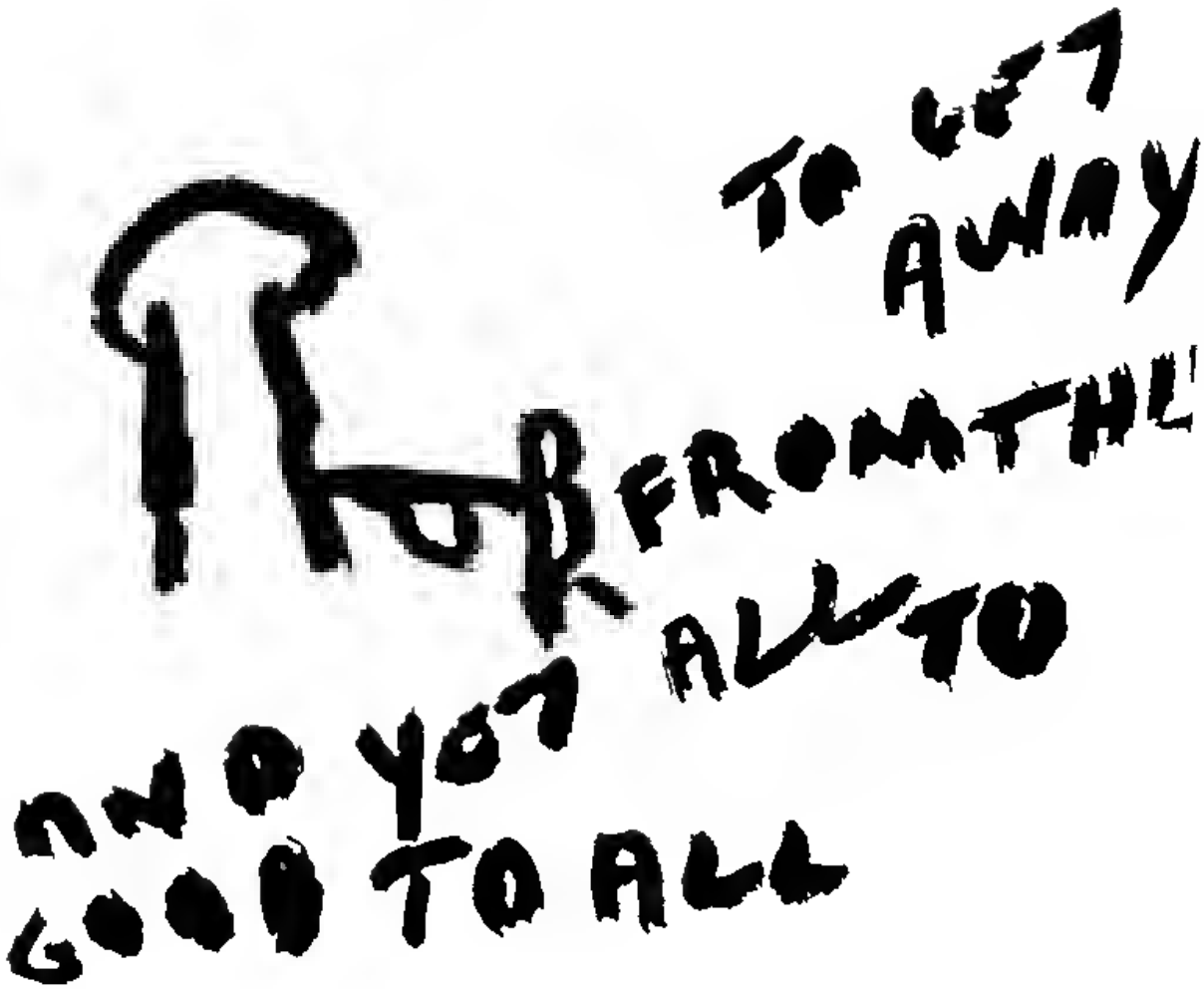

Figure 81

CASE NO 1 *INTRACTABLE INSOMNIA IMPULSIVE VIOLENCE OBSESSIVE PERSONALITY*

PATIENT S ASSOCIATIONS WHILE UNDER HYPNOSIS.

That's silly
Just as though tied up to something, to a tree, could be anything
Like a dog on a chain
Can go so far no further
That s what happens
Could be as others

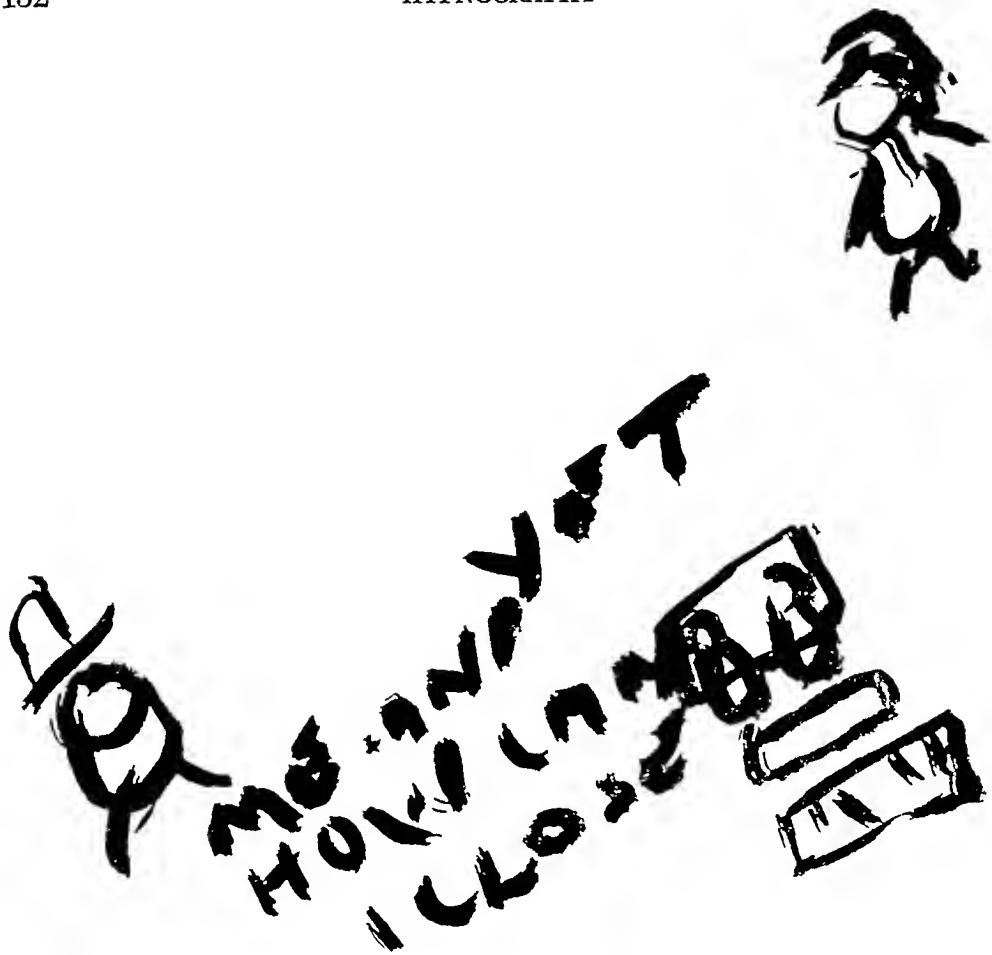

Figure 80

CASE NO. 1. *INTRACTABLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

This is (— wife's first name).

At (—), we used to be like this, always close together in thought, word. and deed.

So far apart.

Would like to get back like this.

Seems to be some barrier on my part that prevents it.

Figure 83

CASE NO 1. *INTRACTABLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Dad and me sawing up wood
Used to like doing it with dad
Mum would think I ought to be inside helping her
Washing the napkins of the kids, scrubbing the floor
My cobbers would call me sissy, because I could not go out and play with them
Happy sawing with dad
Should have been a flaming girl for mum
Disappointed when I was born
He had two boys by a previous marriage
Cooking cakes, trifling things
Prizes at the show
Hated it all
That's the flaming napkins on the line
That's polishing the floor
That's the wash trap in the wash house

Figure 82

CASE NO. 1. *INTRACTABLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Uncle (—'s) truck.
Going to the quarry at (—).
On the way, he got playing with me.
Put his hand over mine.
Came out of the side of the truck, standing up like that.
Made me lie down in the back of the truck.
Awful.
Wife and kids of his own, too.
Size of his privates enough to frighten anyone.
Said, 'don't tell your mother or your father.'
Gave me a shilling.
Never told. Threatened to kill me if I did.
It happened again.
Either he was bad, or else I was.
Feel awful.
Wanted to show me how he did it with a girl.
Could not get to do it with her.
Said, 'you flaming siss.'
The girl did not mind.
She laughed while he was doing it to her.
Then she said, 'you get on top too.'
Couldn't.

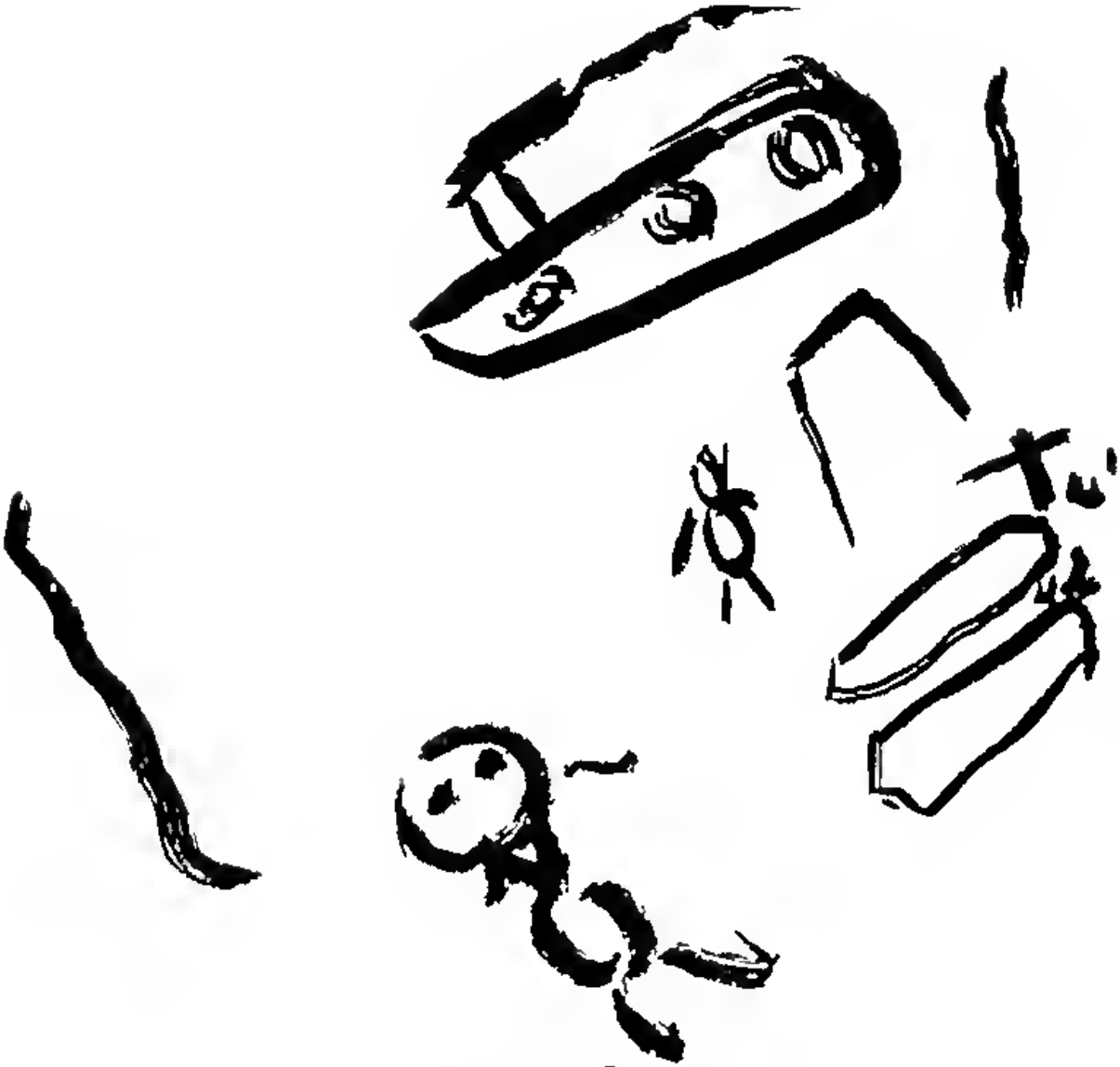

Figure 85

CASE NO 1. *INTRACTABLE INSOMNIA IMPULSIVE VIOLENCE OBSESSIVE PERSONALITY*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Send mum and dad to England
Like to see England again before he dies
Got to work a lot to get the money to send them
Gets something wrong with his eyes
Take him to Eye and Ear Hospital
Cataract
Died on me
Then mum, too
There are the graves

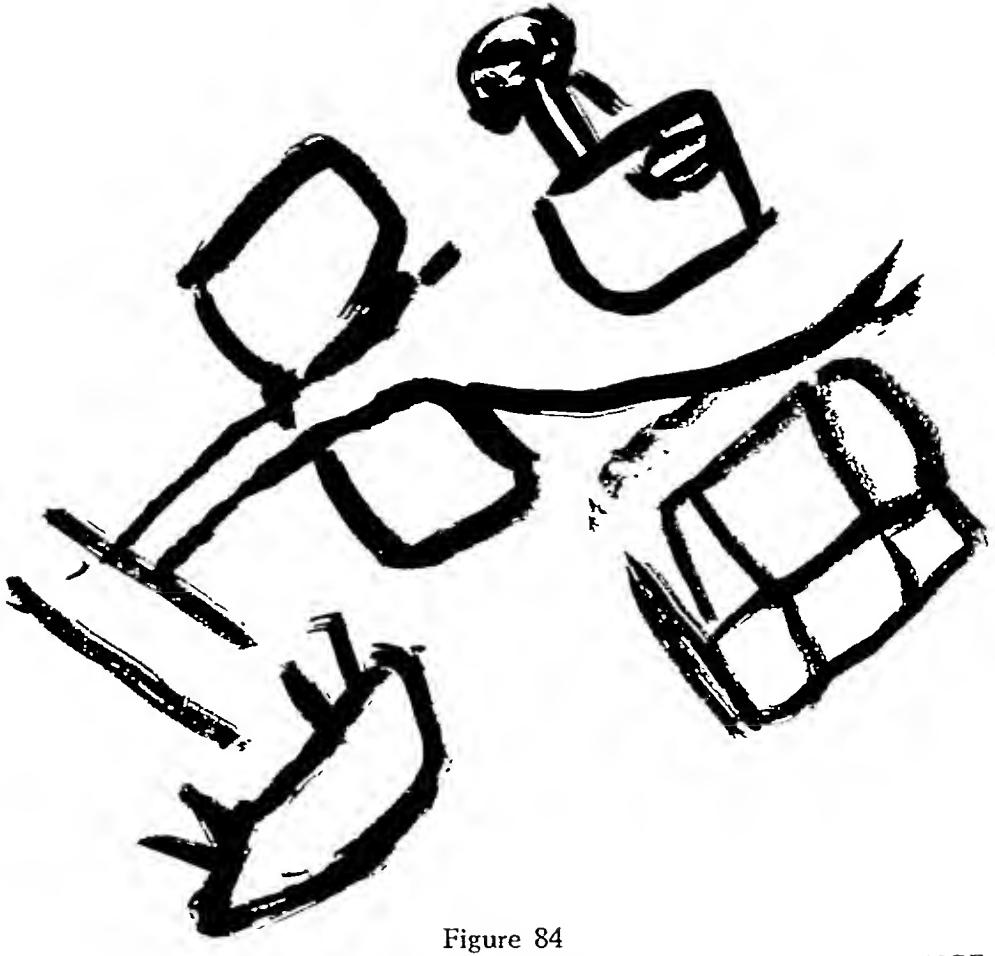

Figure 84

CASE NO. 1. *INTRACTABLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

That's our place at home.
Used to cross the road to the public gardens.
Back lawn.
Used to go and spy on couples.
Climbed a tree, sneezed as he was making love with the girl.
Pulled my pants down, took a switch, and made her belt hell out of me.
Because I would not cry, threw me in the lake over here.
When I got home, mum gave me a hiding for falling in the lake.
Never told her what happened.

CASE HISTORY NO. 2

The patient entered the consulting room walking sideways This was necessary as her head was firmly fixed over her left shoulder There was obvious spasm in her right sterno cleido-mastoid muscle She immediately announced that she had already been under treatment from fourteen different doctors These included physicians, and psychiatrists, a medical hypnotist, and more recently, an orthopaedic surgeon She then opened a brown paper parcel, and displayed an elaborate surgical brace which had been designed in an attempt to keep her head straight

She was a married woman in her middle thirties She had suffered from the spasmodic torticollis for some ten years, but was unable to give any definite details about its onset Over the last two years the condition had become increasing worse

It was thought that she might be helped by hypnotic suggestion Rapport was established during a couple of unhurried interviews, and she was easily hypnotized by switching from suggestions of relaxation to levitation In two or three sessions a considerable depth of hypnosis could be obtained

An odd complication arose at this stage It was found that the spasm of the muscles of her neck could be relieved by suggestion, but the relief was only momentary Her head would return to a normal position, and then all of a sudden the muscles would fly into violent spasm, and jerk the head around again The suddenness and violence of these contractions were really alarming In hypnosis it seemed that all the muscles were completely toneless save for those which remained in spasm turning her head When these would finally give way in relaxation the whole of the musculature of the neck was flaccid Then the affected muscles would go into sudden violent contraction, while the other muscles remained flaccid The head would be jerked around with the utmost violence without the joints being supported in any way by the normal tone of the other muscles After several attempts to maintain the relaxation had failed, it was thought that there was real danger of dislocation of the patient's neck, and the suggestive treatment was discontinued

During the suggestive therapy the patient would spontaneously

Figure 86

CASE NO. 1. *INTRACTABLE INSOMNIA, IMPULSIVE VIOLENCE, OBSESSIVE PERSONALITY.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

(—). He was run over by a railway engine which cut his arm and leg off before we could pull up.
He lost his arm and leg.
I signalled to the driver, but he could not pull up.
It was awful getting him out.
Flesh and blood and bits and pieces of flesh.
We took him to the (—) hospital.
He got well again.
He was drunk, and we were pulling out of (—) with a double-headed load.
The guard gave us the O.K., and the driver gave us the O.K. to go ahead.
I saw him right in front of the engine.
It went right over him.

Figure 89

CASE NO. 2 *SPASMODIC TORTICOLLIS*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

My husband chasing me

abreact conflicts concerning her domestic life; so verbal hypnoanalysis aided with hypnography was instituted. In spite of a continuance of the disturbing domestic situation, the patient made a complete symptomatic recovery.

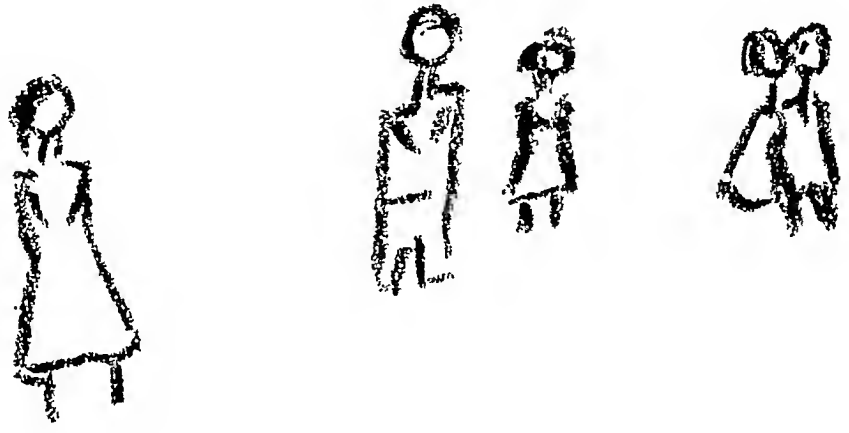

Figure 87

CASE NO. 2. *SPASMODIC TORTICOLLIS.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Me with my head on one side.
My husband and a girl.
My husband kissing a girl.

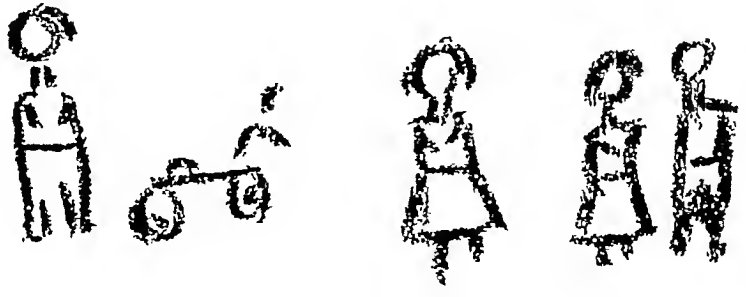

Figure 88

CASE NO. 2. *SPASMODIC TORTICOLLIS.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

My husband and his bike.
I begged him not to go out on it.
The two girls and the boy.

Figure 89

CASE NO 2 *SPASMODIC TORTICOLLIS*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

My husband chasing me

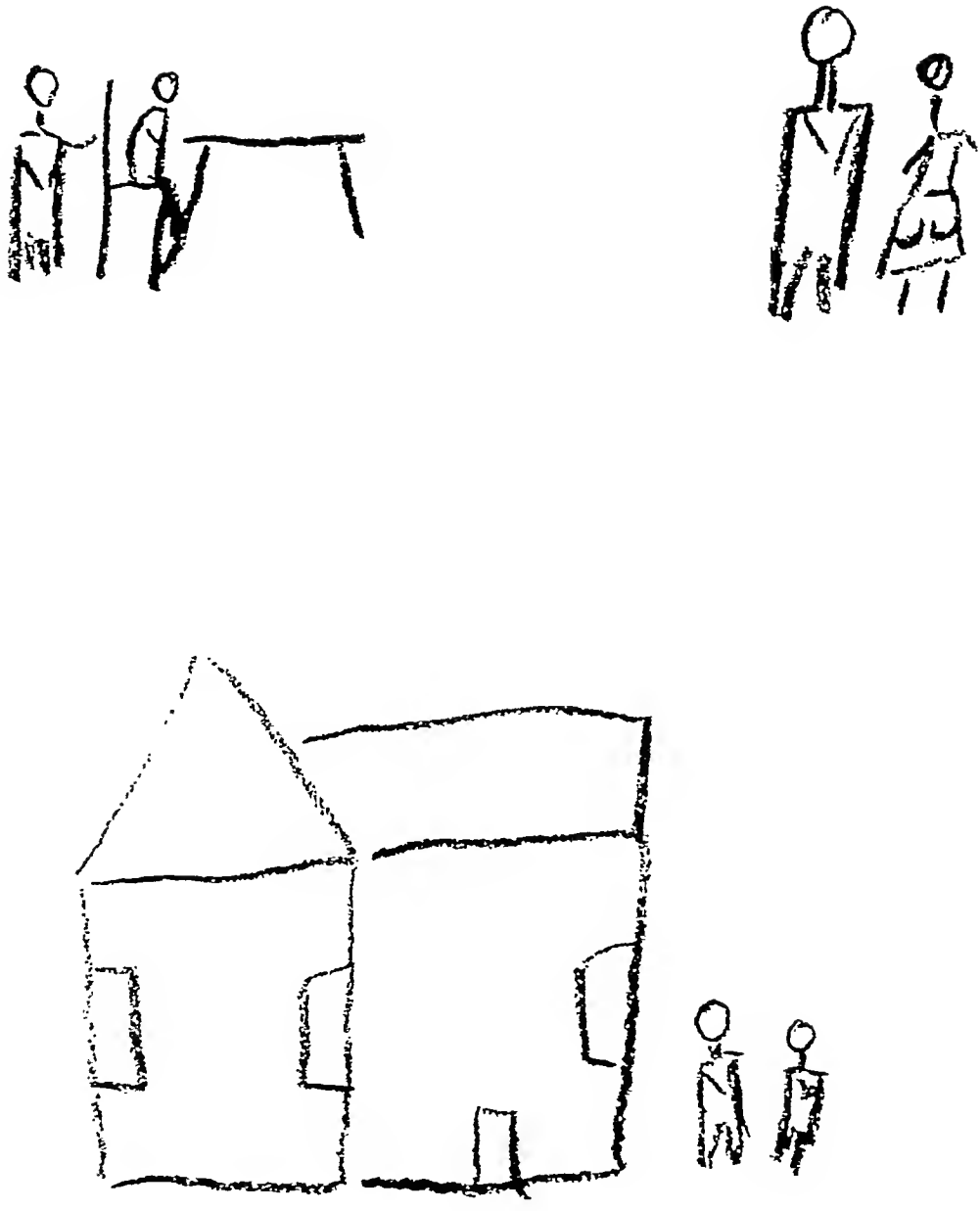

Figure 90

CASE NO. 2. *SPASMODIC TORTICOLLIS.*

Hypnotized. Abreacts. "Sex, he's always at me. White pants. Putting her over his knee. I burned the pants. He would show his boy friend my white pants. I have had enough of sex."

Given Crayon, Draws Figures.

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Me sitting at table, he pulls me back and upends me.

Me with my white pants on, he's always after me.

My house and my two children. He's ruining their lives.

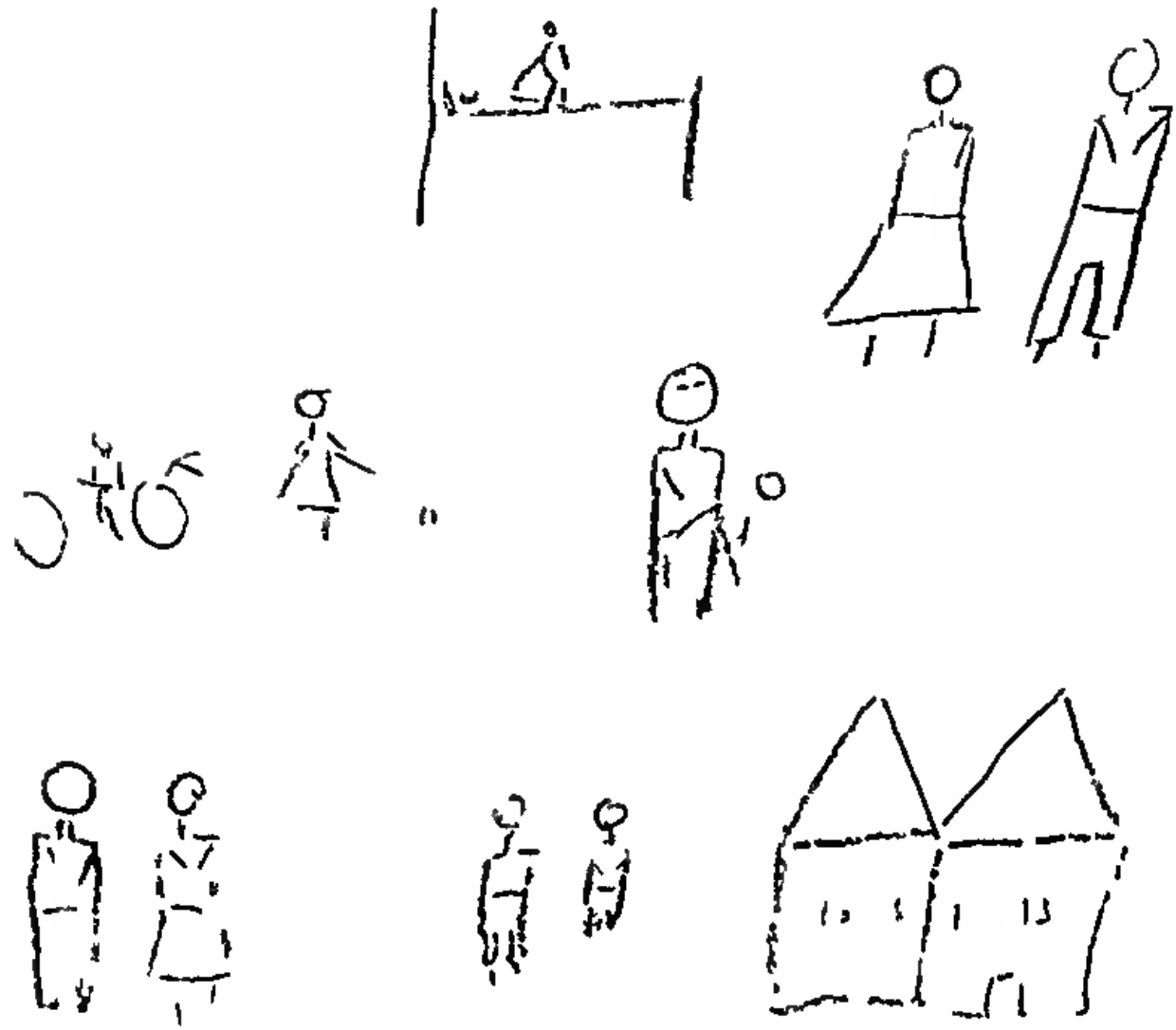

Figure 91

CASE NO 2 *SPASMODIC TORTICOLLIS*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

(1) I hate him
(2) Him belting me
(3) My husband and the kid at (—)
(4) Man on bike exposing himself Me watering the garden
(5) Him upending me all the time to look at my pants
(6) My husband and any girl he upended
(7) My two little boys
(8) Court room

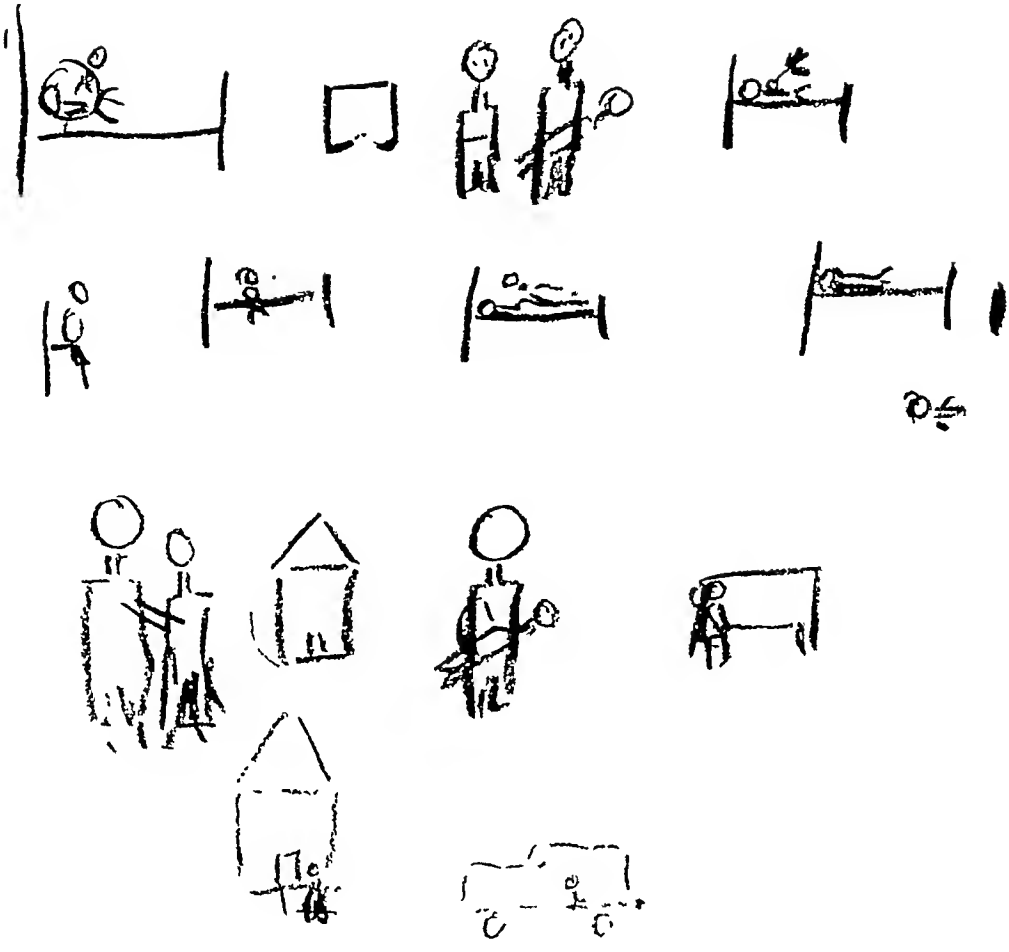

Figure 92

CASE NO. 2. *SPASMODIC TORTICOLLIS.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

(1) Him holding me down.
(2) The pants.
(3) Him showing (—) my pants.
(4) Him biting my nipples and down below.
(5) (—) sitting in the chair. Me having intercourse on the side of the bed in the next room.
(6) Him doing it up my back passage.
(7) My husband having intercourse, the tube of (——), the baby I thought I was going to have.
(8) Him pushing me outside without my clothes on.
(9) The house. I had to run round to the back.
(10) Him belting me.
(11) My husband having intercourse dog fashion way.
(12) Him when he kicked me out, watching me go to a taxi.

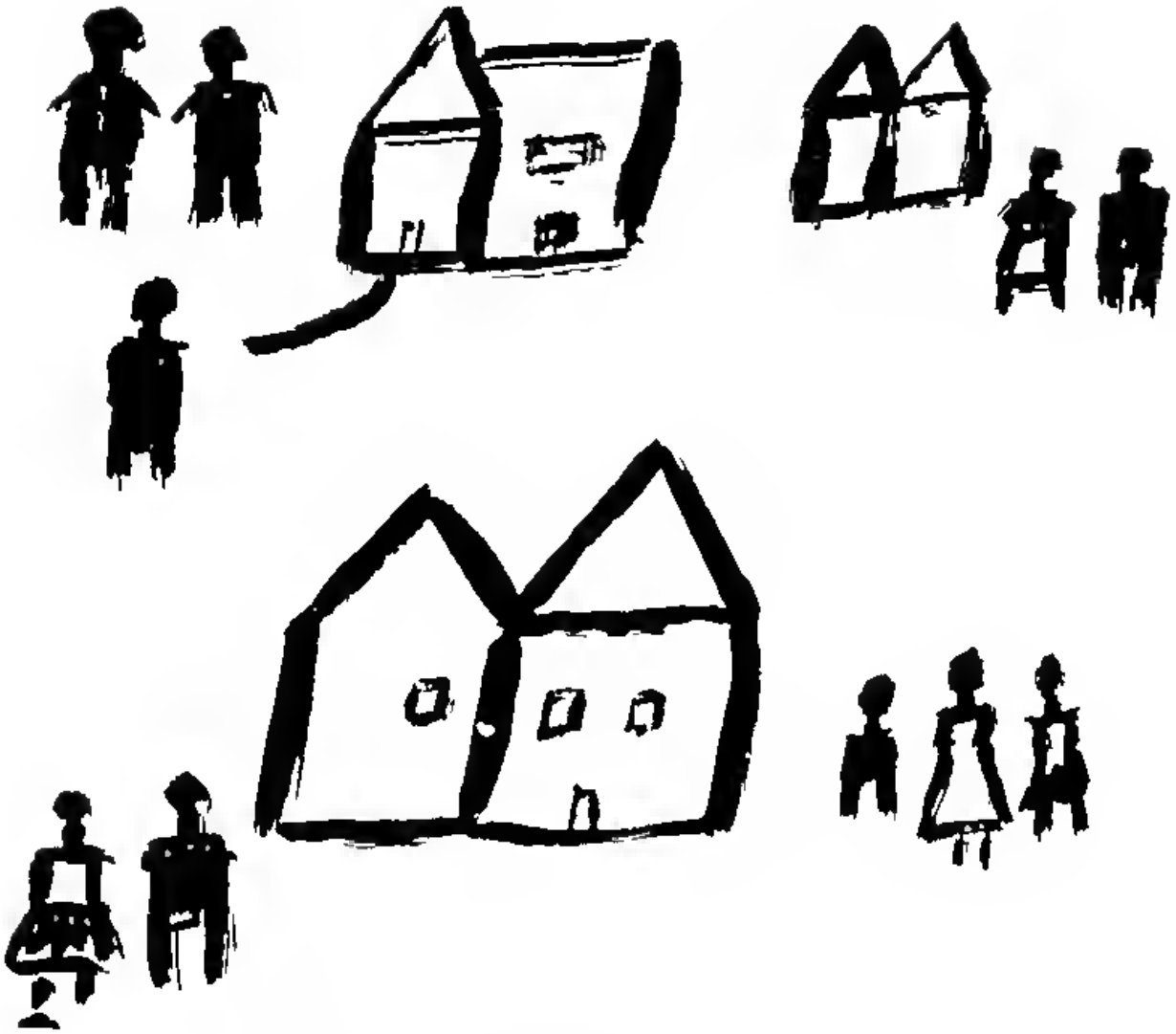

Figure 93

CASE NO 2 *SPASMODIC TORTICOLLIS*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

The two detectives, my house, my husband
They are taking him away
The police station, me bailing him out
The court house
Me and my husband I went with him
The boy The big girl, he chased her
The small girl, he kissed her

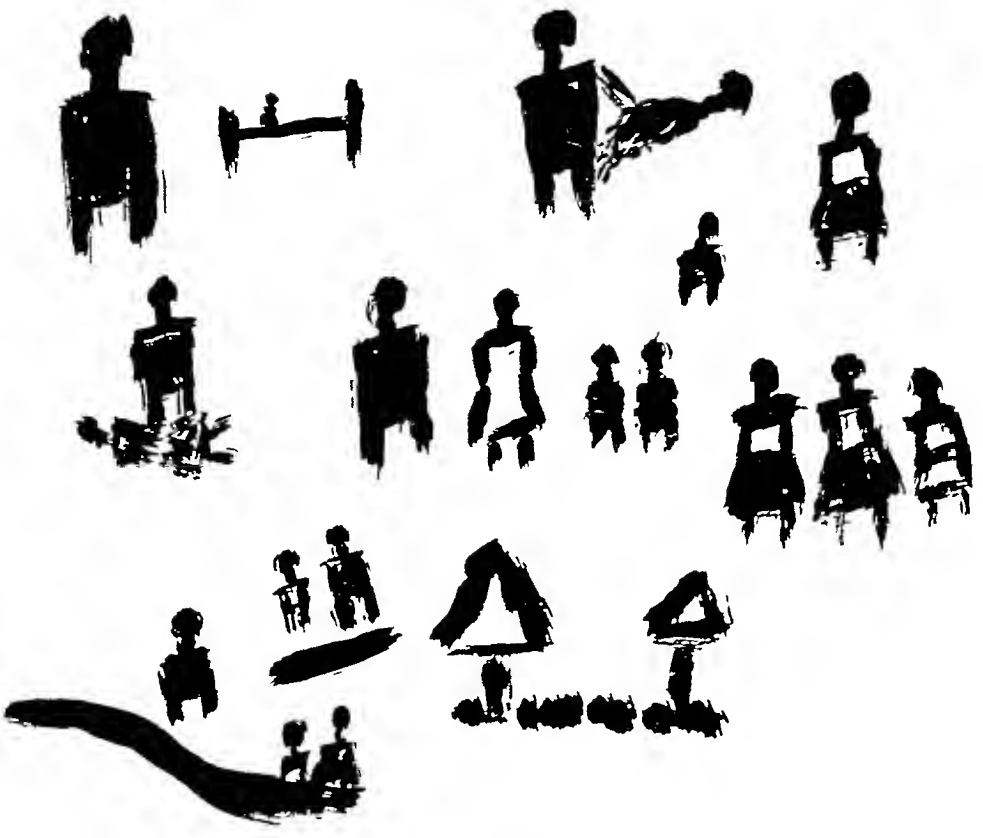

Figure 94

CASE NO. 2. *SPASMODIC TORTICOLLIS.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

My husband coming home drunk.
Me sitting on the bed looking for my husband out the window.
My husband belting me.
He belted me because of girls.
This is the girl he belted me over.
My husband pulling me off the bed and kicking me.
My husband going visiting.
My two beaut kids.
The girls my husband had been acting the fool with in the park.
The park.
The creek where my husband used to go.
Used to mess around with girls.
O! Why did he do it?

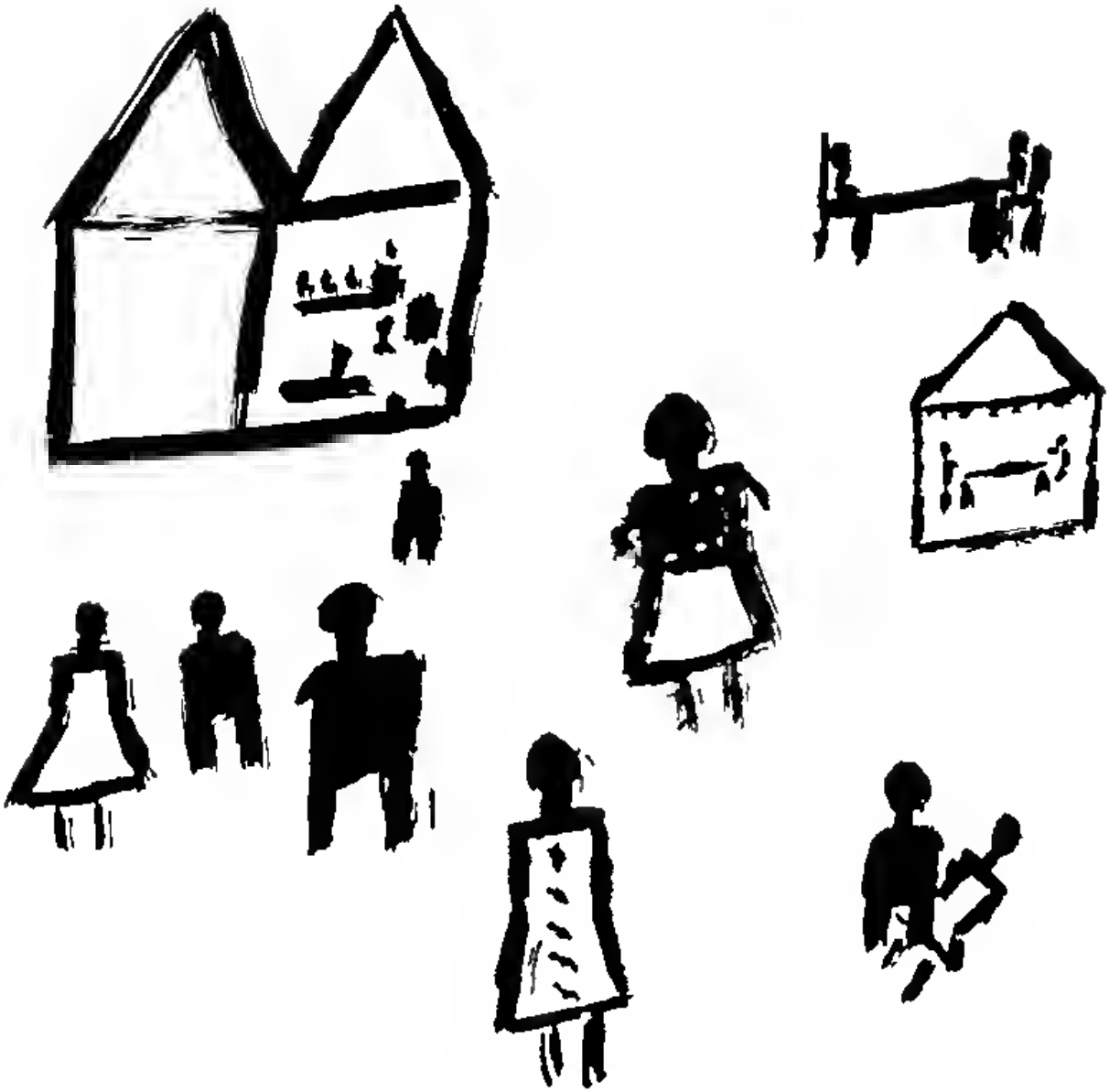

Figure 95

CASE NO 2 *SPASMODIC TORTICOLLIS*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

The court room
The three jury men
The one in the middle is Mr (—)
My husband
Me sitting watching
The man trying to take my husband's photo
Me, my husband and lawyer
The girl my husband undid the buttons.
My mother in law I was wondering what she would think.
My parents having their meal while my husband is playing table tennis with the girl
Him upending my girl friend

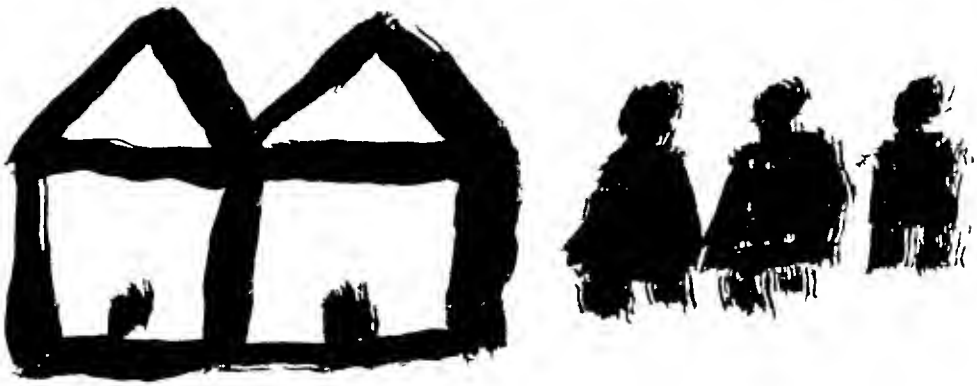

Figure 96

CASE NO. 2. *SPASMODIC TORTICOLLIS.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

The court house.
The girls, the boy.
He smacked the biggest one.
He pulled the boy's trousers down.

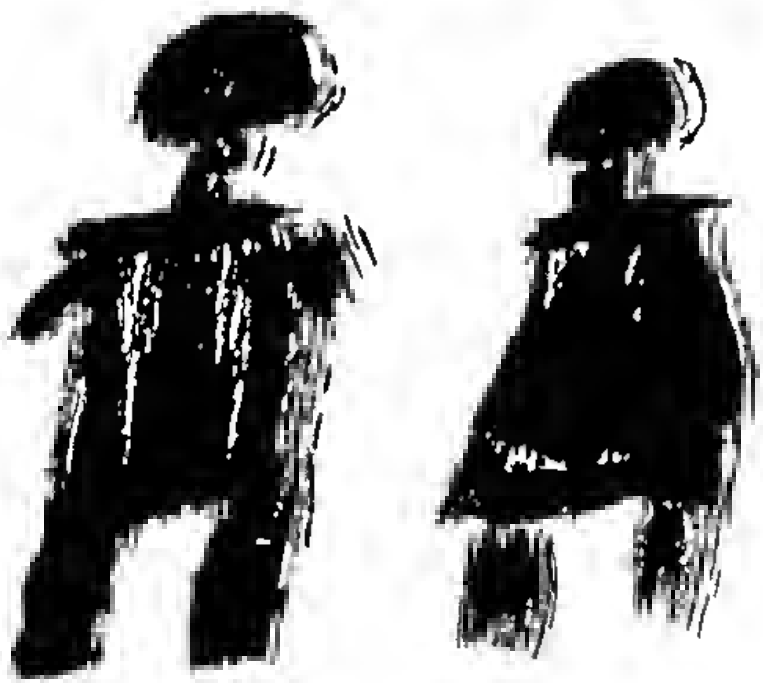

Figure 97

CASE NO 2 *SPASMODIC TORTICOLLIS*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

My husband and me, I turned from him
I did not want to (weeps)

Comment—This was the basis of her torticollis

Figure 98

CASE NO. 2. *SPASMODIC TORTICOLLIS.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.
My husband and me in bed.
He says he strips girls.

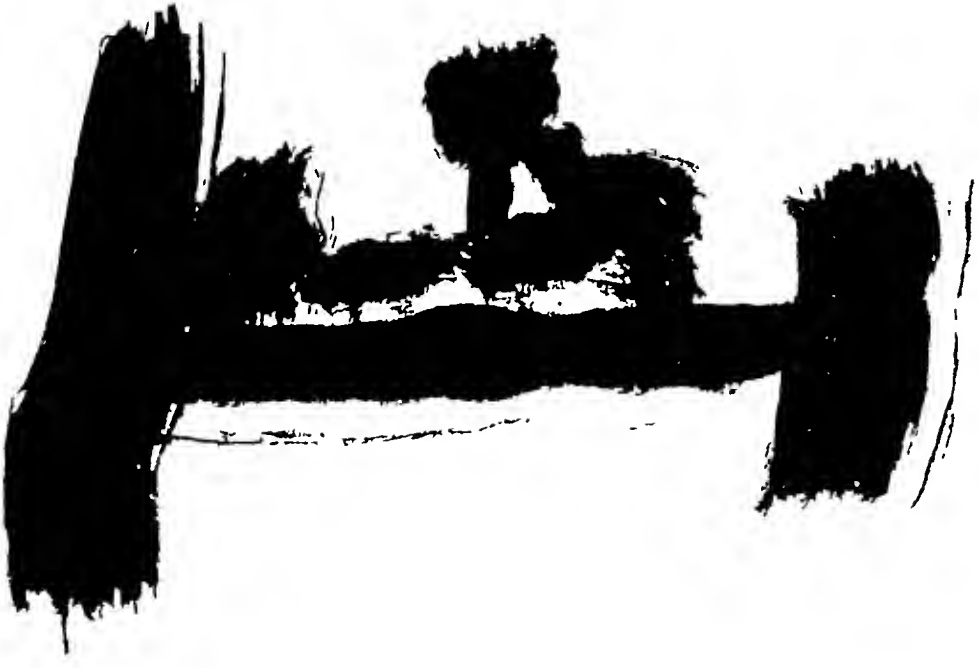

Figure 99

CASE NO. 2. *SPASMODIC TORTICOLLIS.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.
My husband belting me.
Living in fear.

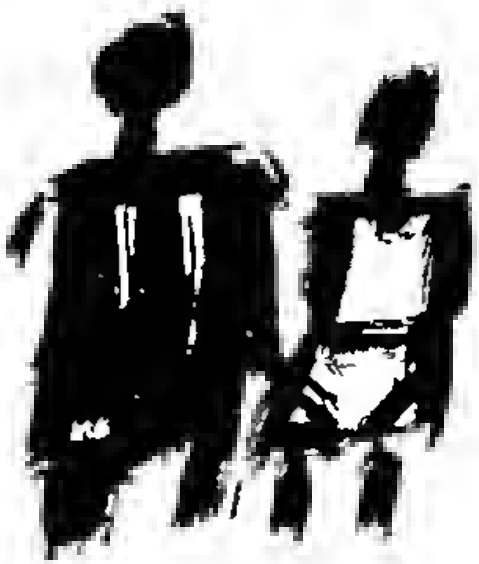

Figure 100

CASE NO 2 *SPASMODIC TORTICOLLIS*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

My husband always pulling up my dress to see my pants.

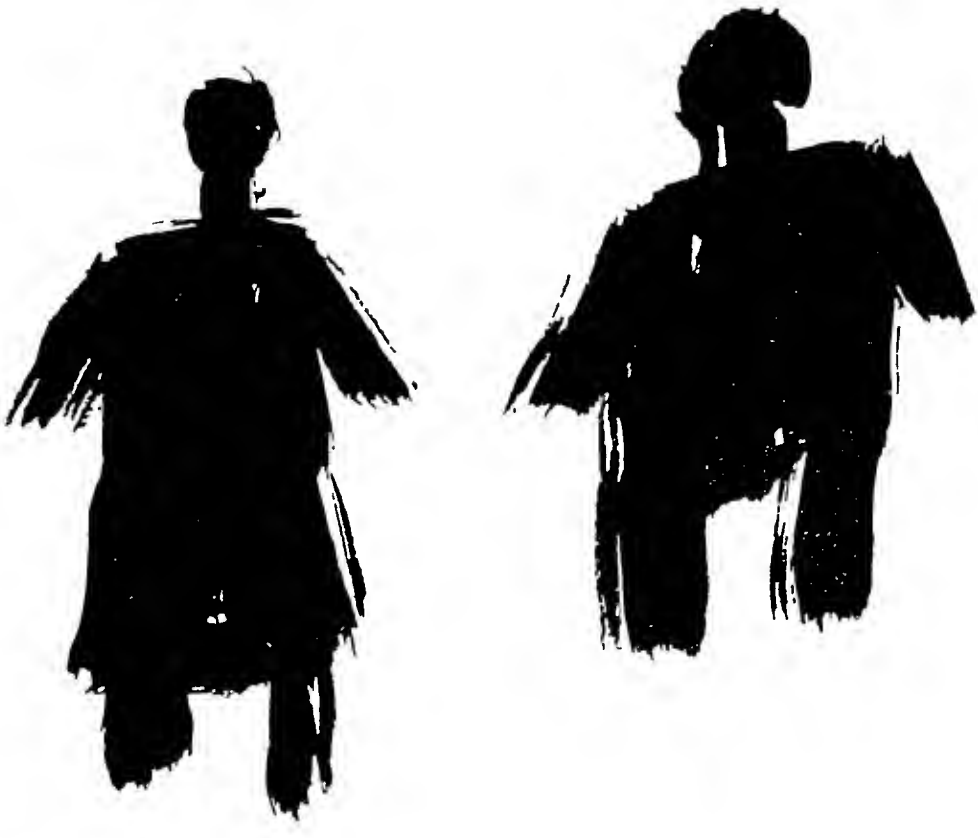

Figure 101

CASE NO. 2. *SPASMODIC TORTICOLLIS.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

My husband and me.

I turned from him because of girls.

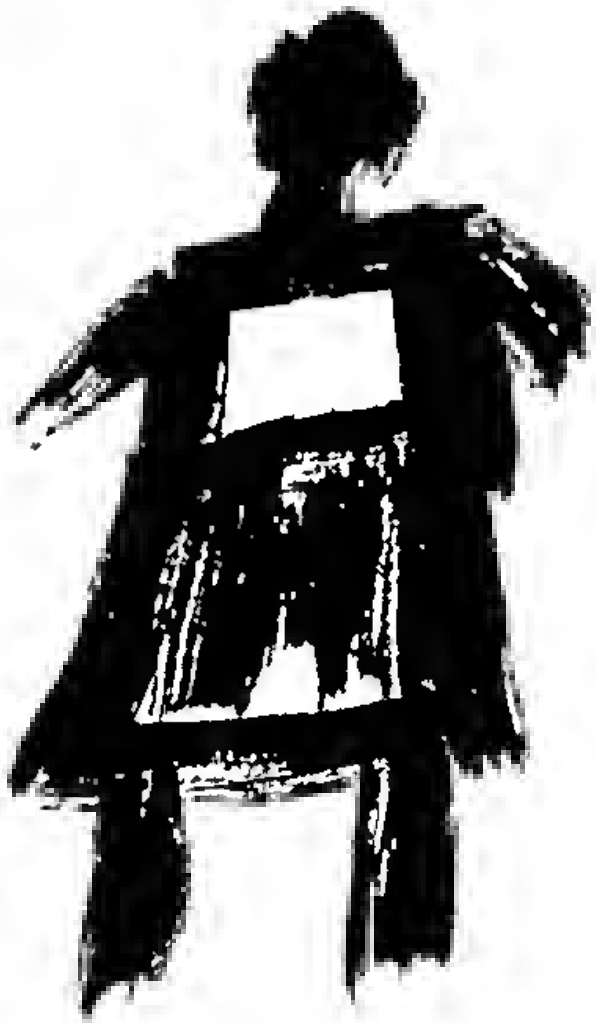

Figure 102

CASE NO 2. *SPASMODIC TORTICOLLIS*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

That's the girl
He's all the time joking with them
I can't stand it

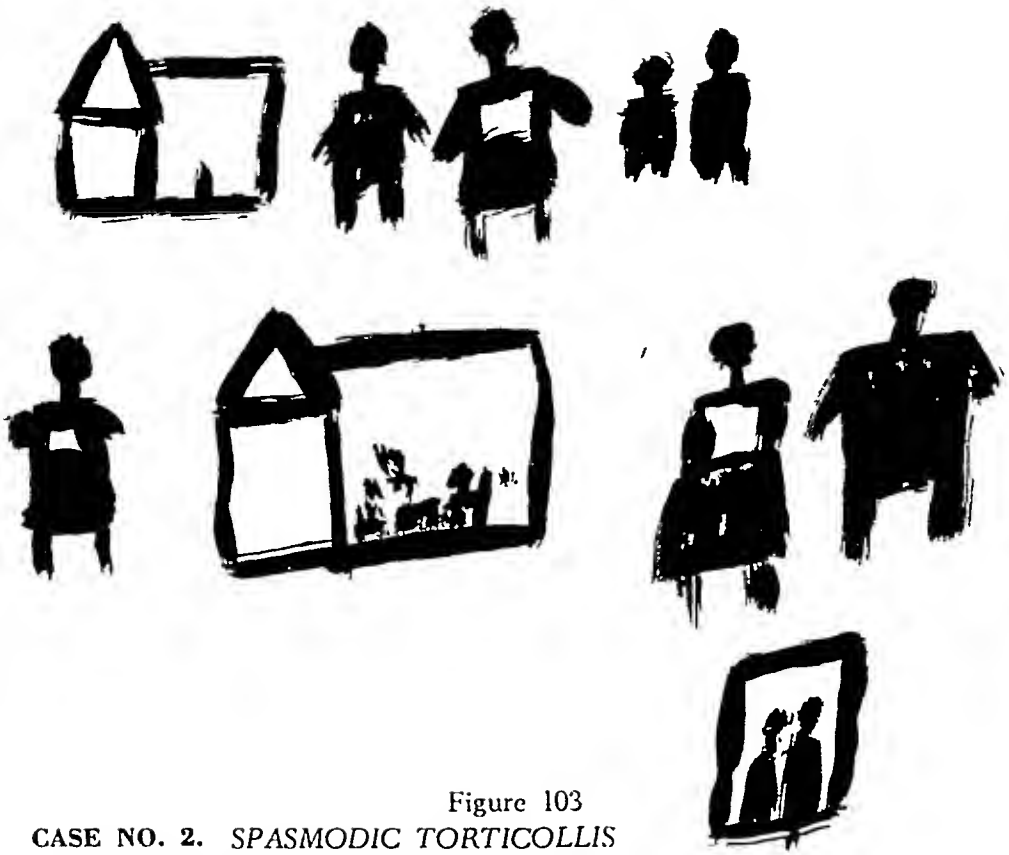

Figure 103

CASE NO. 2. *SPASMODIC TORTICOLLIS*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

(1) My house.
I went to work to help my husband build it, to try and make him happy and contented.

(2) My husband and me.
I turned, I did not want him.
I tried to help him.

(3) My two children.

(4) The girl at (—).
My husband likes her.

(5) My house, my husband, me, my mother-in-law.
Arguing about the girl at (—).
I said I would tell the children what a beast he has been.
He hit me with a piece of wood.

(6) My husband and me.
I want happiness.

(7) The mirror.
My husband used to stand me in front of it without any clothes on.
I used to see his face.
I was frightened.

Comment—All the time she is drawing the pictures, she shows great distress with weeping and unverbalized phonation.

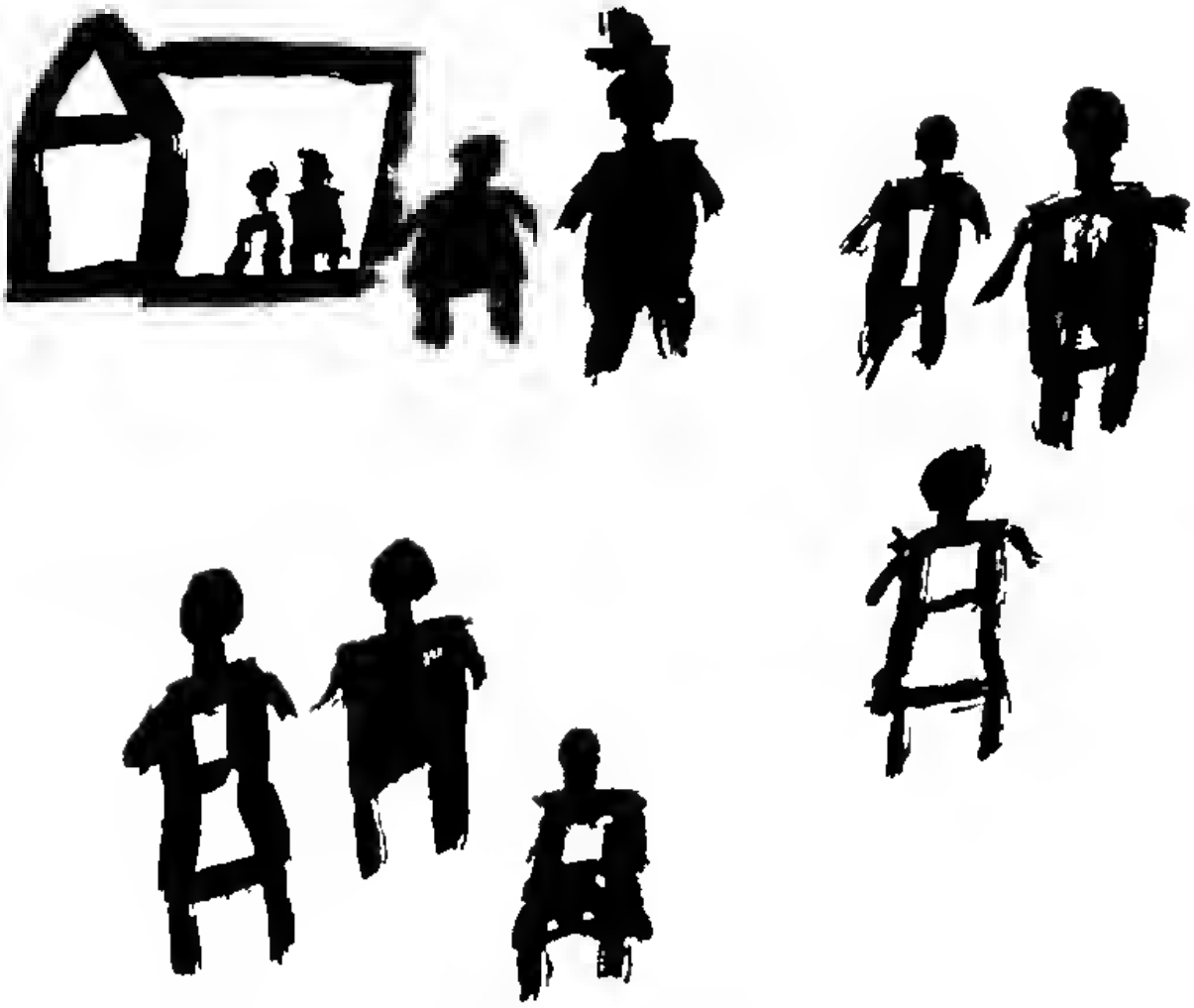

Figure 104

CASE NO 2 *SPASMODIC TORTICOLLIS*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

(1) My house
My husband and me arguing
He was going to (—) to see the girl

(2) He told (—) to get the police because I threw a vase at him
He put his foot through mother's screen

(3) My husband
He went to a solicitor to safeguard himself
I want to be happy

(4) Me and my husband
I want to turn to him but I can't because of girls
That's the girl

(5) That's me
I want to be happy

CASE HISTORY NO. 3

The patient is a forty year old psychopath. She has a long history of morphia addiction, alcoholism, promiscuity, Lesbianism and suicidal attempts. There is quite a religious background to her life; and during treatment it became clear that she did many of her anti-social acts with the perverted object of paying out her church, and paying out God.

Hypno-analytical treatment had to be concluded abruptly as she had to leave the institution where she was working. During the treatment, and for some time afterwards, she was symptomatically improved.

Figure 105

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Our cat
Named Peter
He went away
He's a black cat.
A nice cat

Comment—The difference in character between this painting and all her subsequent paintings makes it clear that this was a screen painting

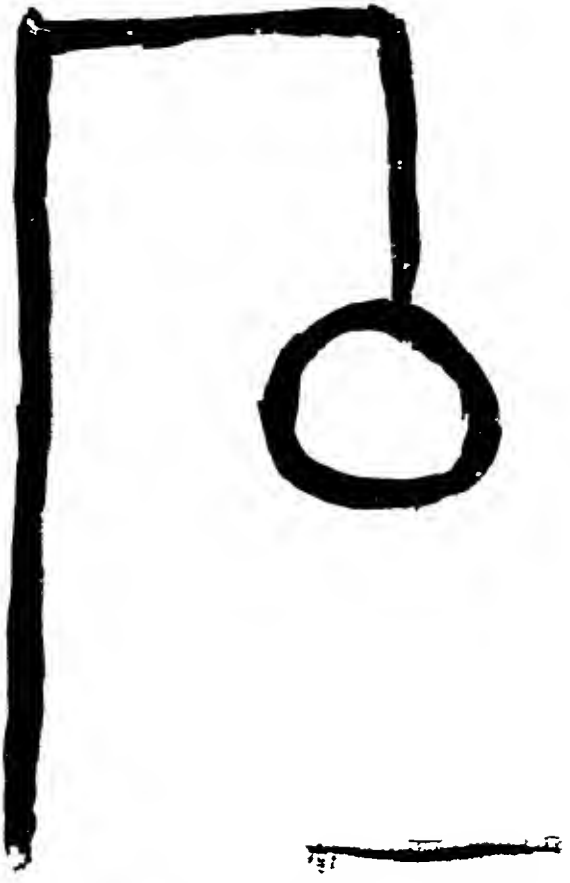

Figure 106

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

The gallows.
Where they hang me.
It's me they're going to hang.
I don't know why.
Because I might do something.
I might kill somebody.
I don't know whom yet.
There is somebody I might, if I ever meet him.
He's a priest.
He was going to kill me.
He was going to kill me.
He wanted my money.
He did things to me.
He did bad things.

Comment—While she was drawing the picture, there was no phonation or abreaction, but she looked grim and determined, with tight lips and flushed face.

Figure 107

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

The hangman
That's a hangman a mask over his face
He's going to pull a trapdoor
It's me he is going to hang

Figure 108

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

A coffin
My mother was in it and my uncle made me take off the top and I did not want to
He made me stand at the top of it
I did not want to do it
I was frightened
I have always been frightened of coffins

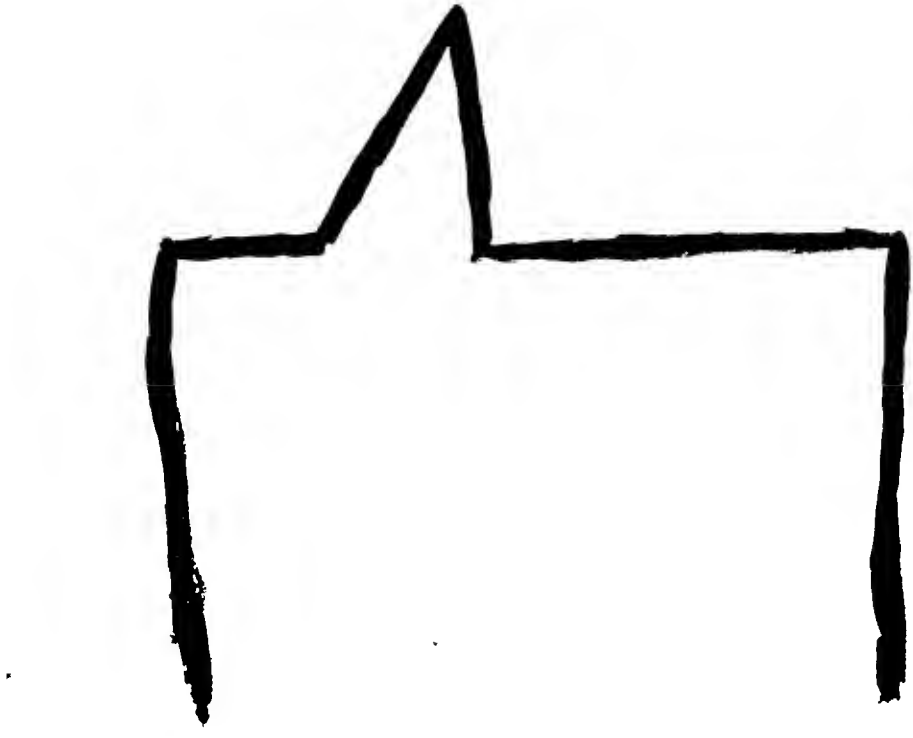

Figure 109

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

A church.
A little church in (—).
I met somebody there.
He was a priest in that church.
He made love to me.
I did not know.
I did not know he was going to do things like that.
He kissed me and other things.

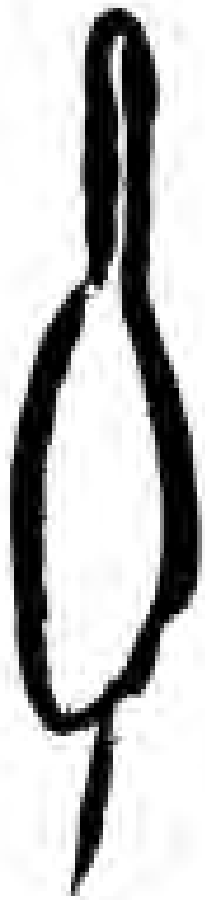

Figure 110

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

A bottle
Wine I think
I think he was going to poison me with it
He gave me an awful lot of wine and tablets
He made me sick with tablets

Figure 111

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Gallows.
They are going to hang me.
I don't know why.
I must be going to kill somebody, I think.
A priest.
I am frightened of him.
I am frightened of him.
He's mad.

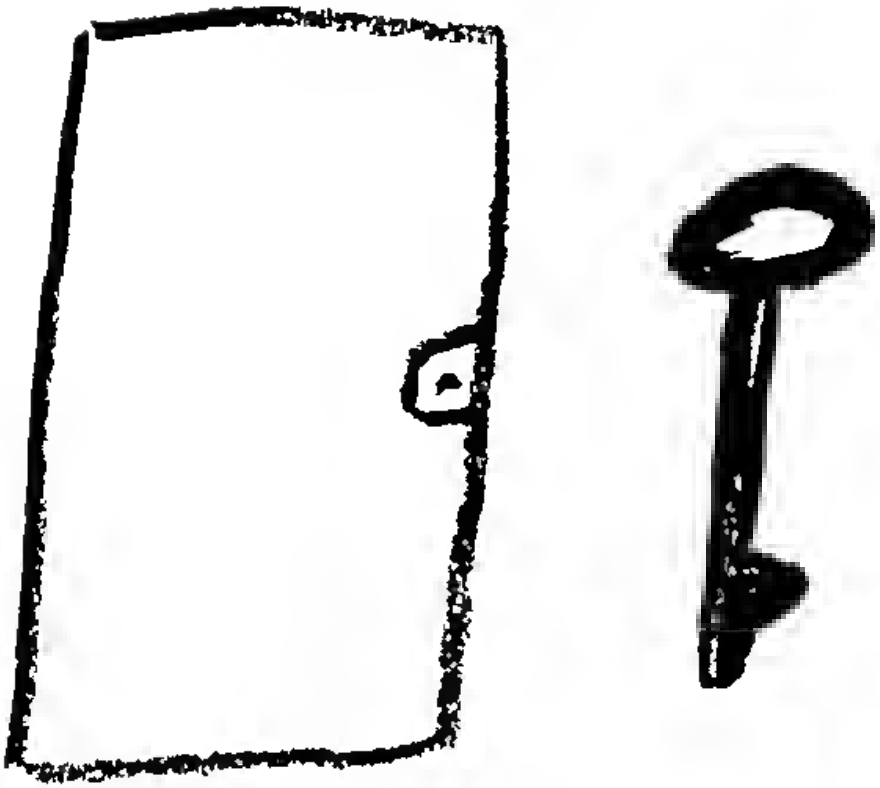

Figure 112

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

A door
A door of a room
(— s) room
He locked the door
He pushed me on the bed
He took off my clothes
He locked the door
He pushed me on the bed
He hurt me
He did something bad to me
He had intercourse with me
This is the key

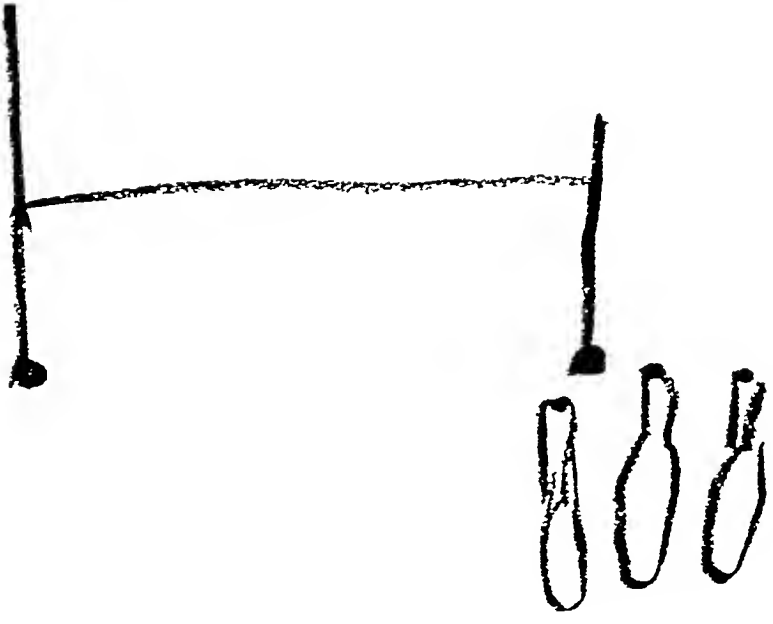

Figure 113

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

A bed.
(—) pushed me on the bed.
A lot of empty bottles in the room.
He'd been drinking a lot of wine.

Figure 114

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

A ship
I don't know what ship
The (—) I was in it
I would like to go in it again but on my own
I would like to be on my own in it
So that I would not have to talk to people
I could not get on my own

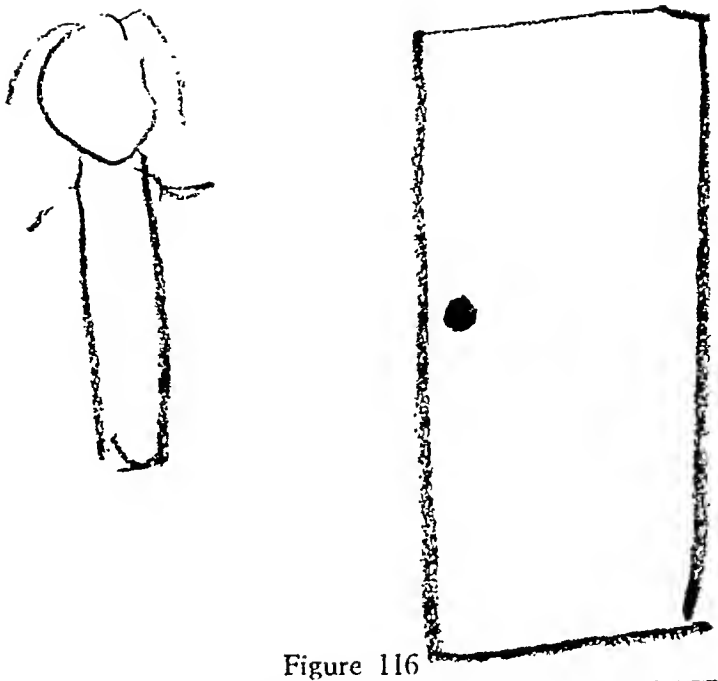

Figure 116

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

That's Sister (—).
That's the medicine press.
She said I had been at it.
That's why my mind has not been on my work.
I have not been at it.
It's not true.

Figure 117

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

A ship.
I would like to go away in it.
Away from everyone.

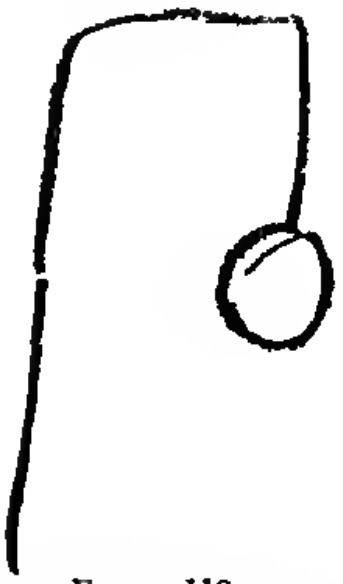

Figure 118

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Gallows
I don't want to be hanged
I'm frightened of it
I am not going to kill anybody
I must not
Somebody said once I would be hanged one day
It was my grandmother

Comment—Made with increased depth of hypnosis

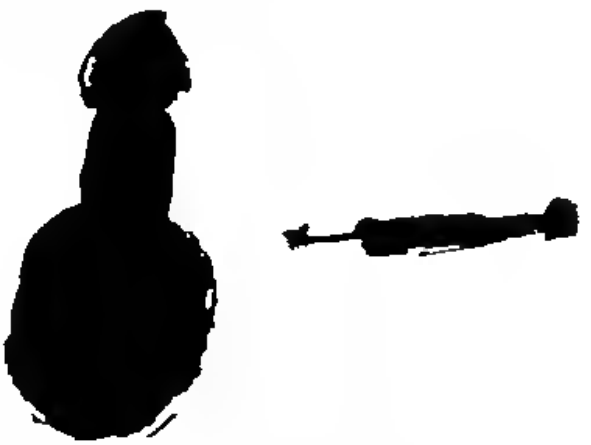

Figure 119

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

The big bottle of morphia I had
That's the syringe I have
I took it

Comment—Patient hypnotised by raising of arms and given paint brush and black paint in place of the crayon used previously

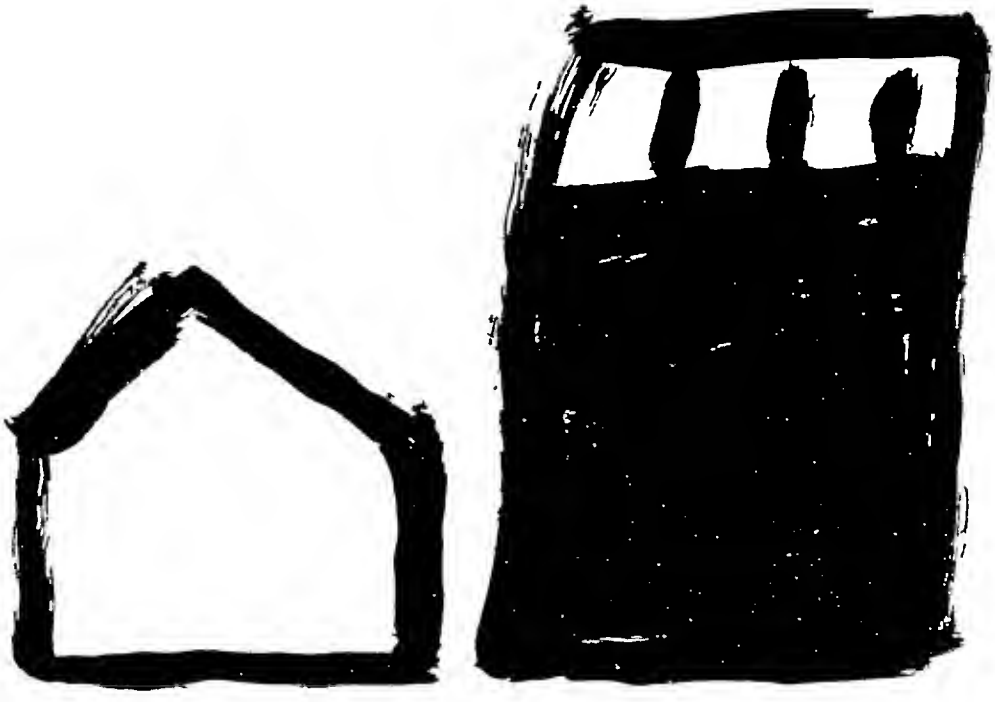

Figure 120

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

A house, a hotel.
A house I lived in with my mother and father.
My grandmother owned that hotel.
I used to get a lot of beltings there.
They said I was bad.

Figure 121

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

That's (—) he's a (patient's mother's maiden name)
He always did the right thing
That's me
I was not a (—) so I always did the wrong thing
That's my scooter
That's a kitten
I never had him long enough to give him a name
My *mother sent* I m away
That's a nun who taught me in the convent
She said I was bad too because I said I would get the police if she hit me again

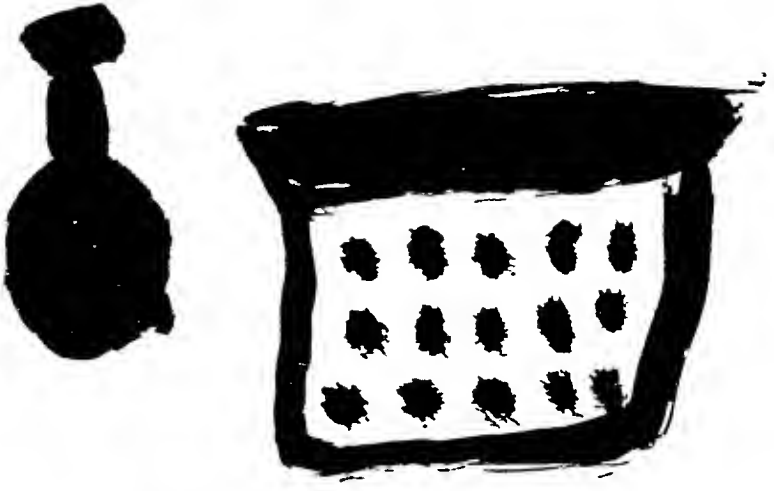

Figure 122

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Typewriter.
I got tired of it.
Awfully tired of it.
I had to type lots and lots of papers.
A bottle of morphia.
I took it.
I mustn't take it again.

Figure 123

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Gallows
It's me to be hung
I don't know why
They are going to hang me
I don't know I might be going to kill somebody
Men
He was a priest
He was going to kill me
I think he was going to give me something
Poison—because he wanted me to make a will and leave him all my money
I think he was mad
He would say all the things he would do with my money when he had it
He used to get me drunk
He gave me tablets to take because I wasn't very sexual or something
They made me sick.
He was expelled from the monastery
He did awful things, things that were not natural
He did things that were very bad
He used to put something in my mouth
He used to put it in my mouth
He used to take photos, bad photos, sexual photos, photos of me without any clothes on
I used to be frightened he would produce them to somebody
I think they were found when his room was searched
He used to come to my room at night
He used to sleep with me
I got tired of it
He got tablets to give me
That is a ship
I would like to go away on a ship just right away

Figure 124

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Two beds. My bed, another lady's bed.
That's the bell. The lady in that bed used to ring the bell anytime I got out of my bed.
That was because I wanted to get away.
I was frightened they were going to send me somewhere.
I used to try to get out of the window at night.
I did once, but I got caught.
It was because I was mental.
I could hear men talking, they were waiting until I went to sleep, then they were going to take me away.
Sister (—) said they weren't there at all.
I was frightened to go to sleep.
I used to hear them outside the door.
They used to say as soon as I was asleep, they would give me a needle and take me to a receiving house.
I was frightened to go to sleep.

Figure 125

CASE NO. 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

A cupboard in (—)
I got caught at it
The medicine cupboard
I got caught taking morphia out of it
That's why I'm frightened to go down the street in daylight in (—)
Go after dark
I am sure the girl that caught me would tell
I am sure everybody would know

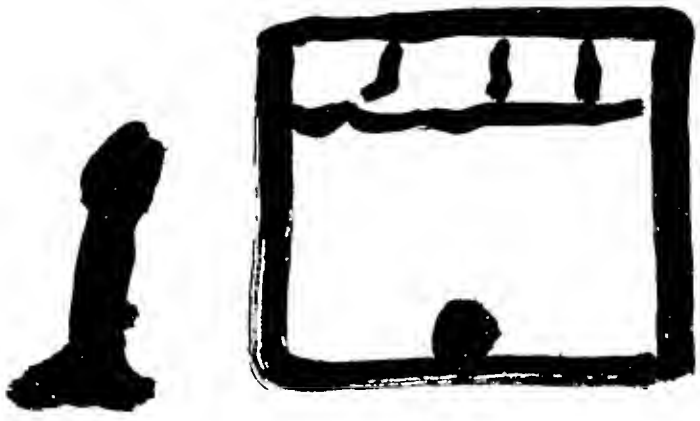

Figure 126

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

A school.
That's a nurse.
She was in charge of it.
She used to give me a lot of morphia one time.
Then one day she had to account for eighteen tubes.
She told someone I took them.
I only took what she gave me.
But everyone up there thinks I did.

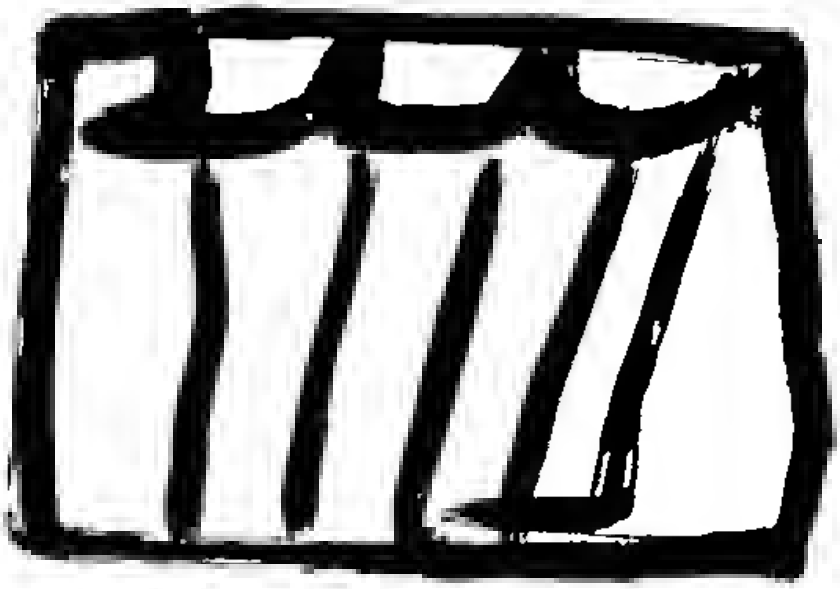

Figure 127

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

The mental hospital

I am frightened if I get sick like that again, I will be put there

Figure 128

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Envelope

The letter I am going to write

It's to (—)

It is about a letter he wrote to me

I am going to write and tell him to mind his own business

He wrote me a horrible letter

He thinks he has control over me and my money, and he has not.

He said there was only a certain amount in the trust account and he complained about my not sending a cheque to him

He has no control over that money at all

Figure 129

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Sister (—) said I am not to write a bad letter.
But I am going to and that's that.
I would like to take all my affairs out of his hands.
He has no right to them.
He has no say about the money (—) left me.
He took it when I lost my bank book.
Even when going on a holiday, he would not give me enough money.

Figure 130

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

That's (—), he's a solicitor.
I could get him to write a letter.
I think I will write it myself.
Type it.

Figure 131

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

That's me
I did something but I mustn't tell
Mustn't tell
Mustn't tell
I did something bad
Mustn't tell
(Resistance, pause, prompting, told 'your hand will paint it')
It's a bottle and a syringe
When I got that letter, I took it

Figure 132

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Me.
I told a lie.
I said I had not taken anything.
But I had.
But I am better.

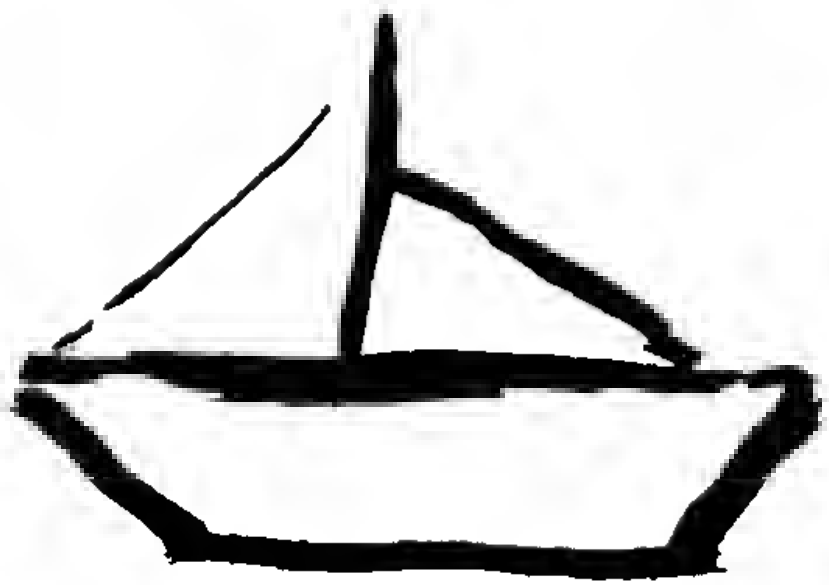

Figure 133

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

A boat
I want to go away in it
Run away
No one will find me
I thought last night I would go down to the beach
I thought I would be safer there
(—) He was trying to make love to me
Wanted me to go away with him in a taxi

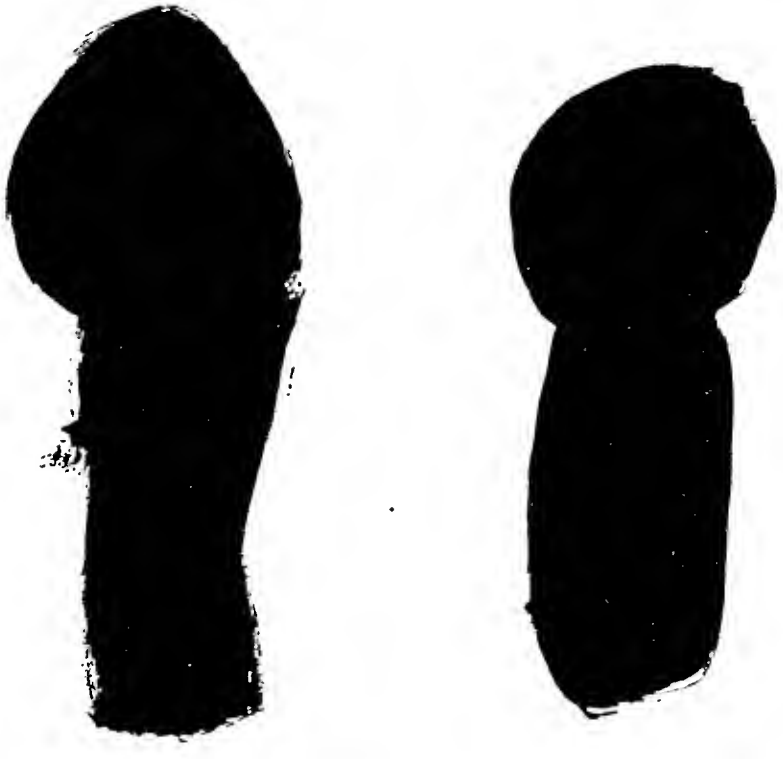

Figure 134

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

It's (—).
That's (—).
I am frightened of both of them.
If he comes near me I will hit him with something.
I don't know what to do with (—).
—). I will kill him, I will.

Figure 135

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Gallows
Frightened, frightened I am going to be hanged on that.
I dream about it at night
I don't know why
I must be going to kill someone, I think.
I don't know who
It might be (X), it might (Y), it might be (Z) (Names men in her life)
I am frightened of them.
(X) is worrying me to do something bad with him
To go away with him to some lonely spot
He wants to have intercourse with me
QUESTION AND (Y)?
He is worrying me over money
It's my money (emotion) I think he is frightened I will spend it.
I will too
QUESTION AND (Z)?
(Z—Z—), he was like (X)
I used to go out with (Z), we used to go out for the whole day in the car
He used to used to have intercourse with me too
He was a priest.

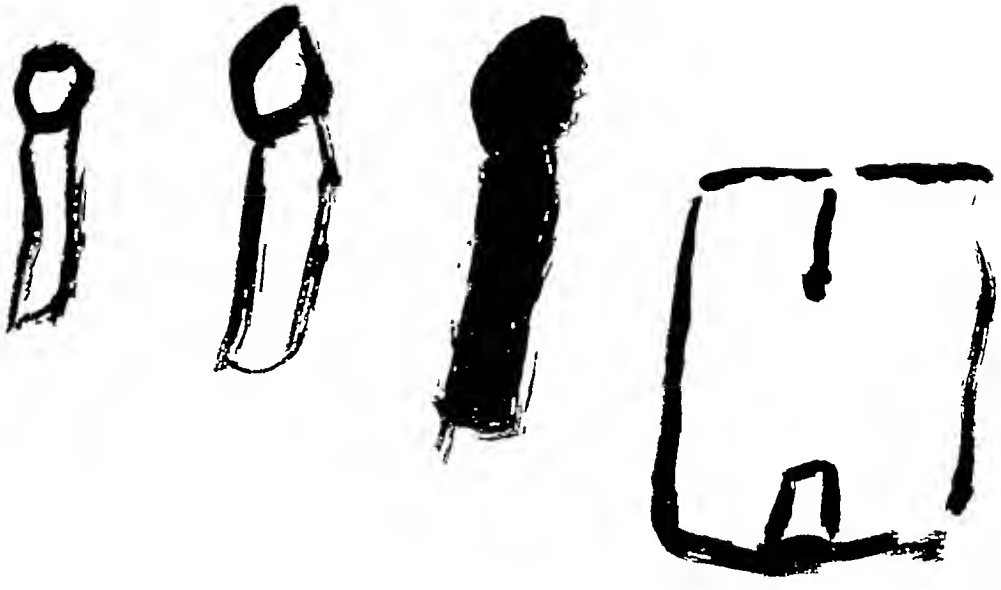

Figure 136

CASE NO. 3. *FEMALE PSYCHOPATH AND DRUG ADDICT.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Sister (—), (—), Dr. (—) - he's the hangman.
A room, (—'s) room, the light and the door.
They watch me every time I go in there.
How long I stay.
I am in love with (—).
(—), he's a patient here.
I have fallen in love with him.
He said he loves me.
When I go into his room, Sister (—) times how long I am in there.
He has only kissed me, that's all.
I did not know that you could love a person like that.
But they are spying on me all the time.
Dr. (—) is his doctor.
(—) used to be a priest.

Figure 137

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

It's a hospital
I don't know where
Sister (—) said I should be in hospital
But I think she just wants me to get away from here

Figure 138

CASE NO 3 *FEMALE PSYCHOPATH AND DRUG ADDICT*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

It's just hopelessness really
It's such a hopeless business
Loving somebody that you are not supposed to and being watched
Terrified that they will find out
It must not be told

CASE HISTORY NO. 4

The patient is a schizoid youth, in his middle twenties, sensitive and inhibited. He has the greatest difficulty in talking to his workmates, and any conversation with a girl of his own age is quite beyond him. He comes of a working-class family, but has an intelligence far superior to his parents, and far superior to others engaged in the factory work which he is doing.

He came seeking relief from his life-long inability to micturate in any public convenience. He is only able to pass his water in his own home. His symptom rules his life. He can only work near where he lives, so that he can return to use the toilet at home. He can hardly go out, or lead any social life at all. He is extremely sensitive about his complaint, and goes to great length to keep it from others. On the few occasions when he has been unable to return home, he has eventually relieved himself only after locking himself in a toilet, and after much long and painful standing.

Figure 139

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Woman (Keeps staring at the painting)
Don't know (Blocks)
Man (Pause)
Sitting on the bed

Figure 140

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Dog
My dog
Micky
Masturbate
Lick
Genitals

Figure 141

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Me.
Micky.
Licking.

Figure 142

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Men
Looking
Laughing

Figure 143

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Me.
Lavatory.
Door Open.
Laughing.
Boys.
At school.

Figure 144

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

A woman just a woman
Don't know
Arm (Blocks)

Figure 145

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Mother, I think.
Wrist caught in wringer

Figure 146

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Chair.
Don't know.
I think it is a man.
Cigarette.
Reading I think.
Think it's Dad.

Figure 147

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Mum standing

Don't know

Figure 148

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Don't know.
Not sure.
Geni'als.
Not mine.
Seem to be Dad's.
Can't remember.
Don't know.
Can't think.

Comment—The first five paintings were done at the initial session of hypnography. The last five were done at the second session. In this session he lacks his previous spontaneity. He seems to have been shocked by what he disclosed in the first session. He blocks more readily, and has greater difficulty in verbalizing his thoughts.

Figure 149

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Face Man's face

I don't know (Blocks) (Long pause, and stares intently at painting)

It's Mum (Blocks)

Comment—His mother is a big plain woman, with a big face and large bust In the waking state the patient is particularly loving and devoted towards her, and extremely respectful

Figure 150

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Mum, I think.
Leaning on the bed. (Blocks.)
Mum relieving herself, I think.
That's a pot.

Figure 151

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Man and woman

I dont know (Blocks)

Figure 152

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Man and woman sleeping together

Don't know

Figure 153

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Think it is Dad and me.

I am not sure.

Figure 154

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS
Dad and Mum
Must have been a long time ago
Can't remember

Figure 155

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCH*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS
Man and woman
Sleeping together
I think it is Mum and Dad

Figure 156

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Think it's Dad lying down, just asleep.

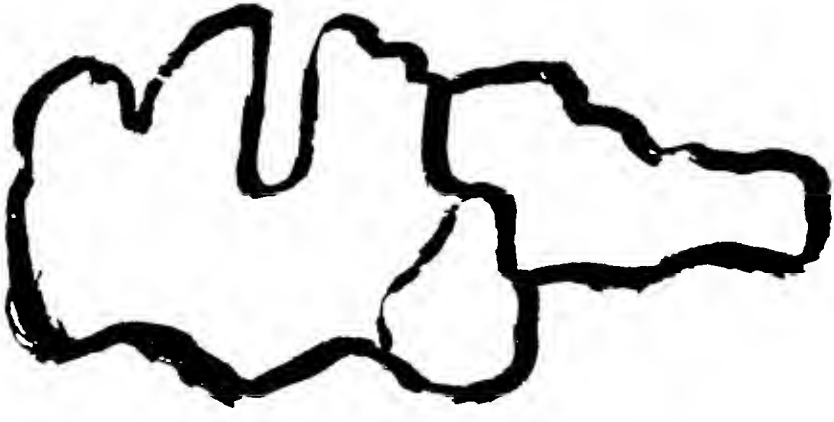

Figure 157

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Just don't know. (Blocks.)

Comment—The picture was carefully drawn, starting from the cleft in the middle. It would seem that the picture has some meaning, and that his denial is a defence.

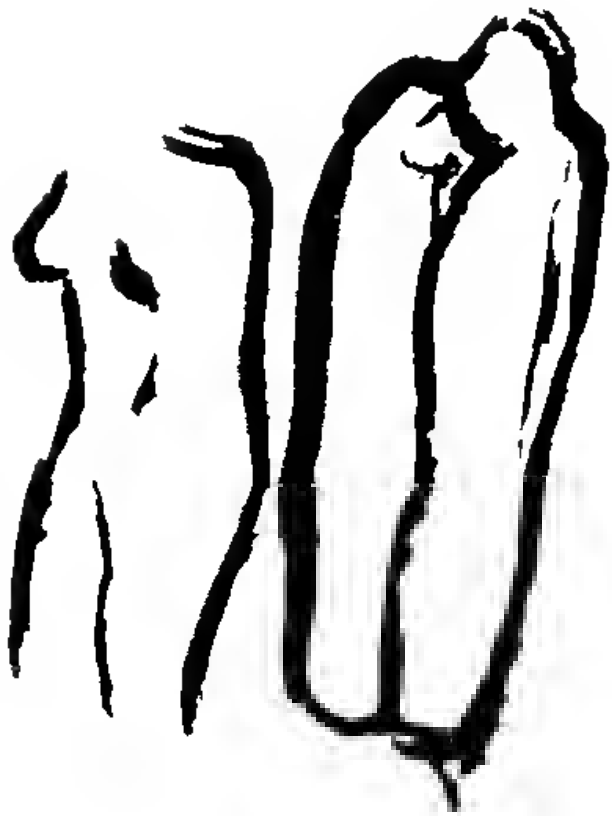

Figure 158

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Still don't know (Blocks)
Think it is a baby, don't know
Think it is Mum
Feeding the baby, I think
Must be me, I think.

Figure 159

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Me.
Mum and Dad.
Might be genitals.
Might be Dad's.

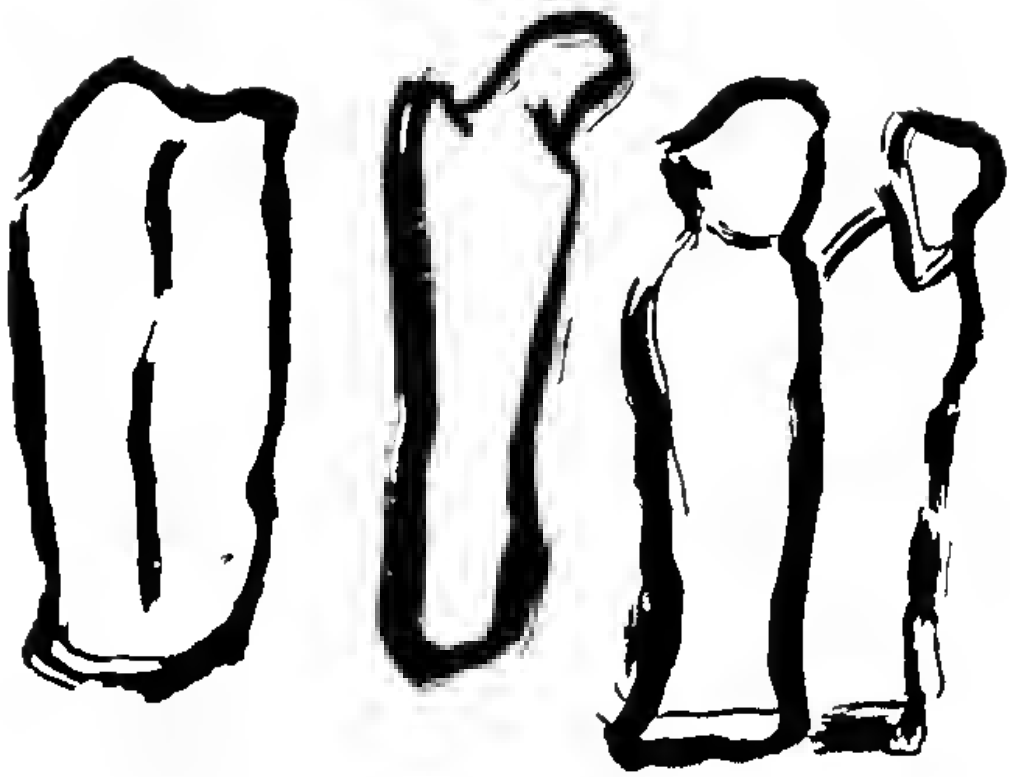

Figure 100

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DISSOCIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Might be mum
Baby me
Two babies I don't know
This one a girl
This one might be me
Q What part of Mum is this?
A Must be genitals

Figure 161

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Seems like three things—two people, two babies, sex.
A woman—Mother I think. Don't know. Can't remember.
Lying together I think.
Can't remember anything.
Reminds me of a cot. Same room.
Not sure, can't remember.
Therapist. You can see it. How old are you?
Patient. Three or four I think.
Therapist. What happened when you were three or four?
Patient. Can't remember. In bed. Had been in bed.
Dad and Mum had come to bed. Can't remember.
Closed my eyes as though I were asleep. Don't remember anything. Embarrassed somehow. Mum made water in the chamber. Seemed sort of annoy me somehow. Can't remember. No, just don't know.
Someone undressing, I think. Not sure, but think it was Mum. Just a glimpse. Can't remember.
Nothing else. That's all, no more.

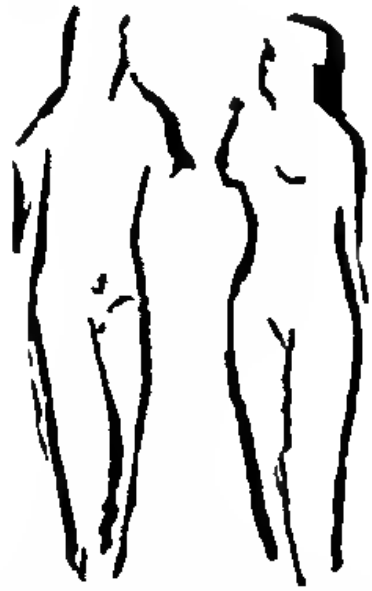

Figure 162

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

A man and a woman
Don't know (Pause)
Don't know
Might be Dad, but don't know, don't think so
Don't know Don't know anything (Blocks)

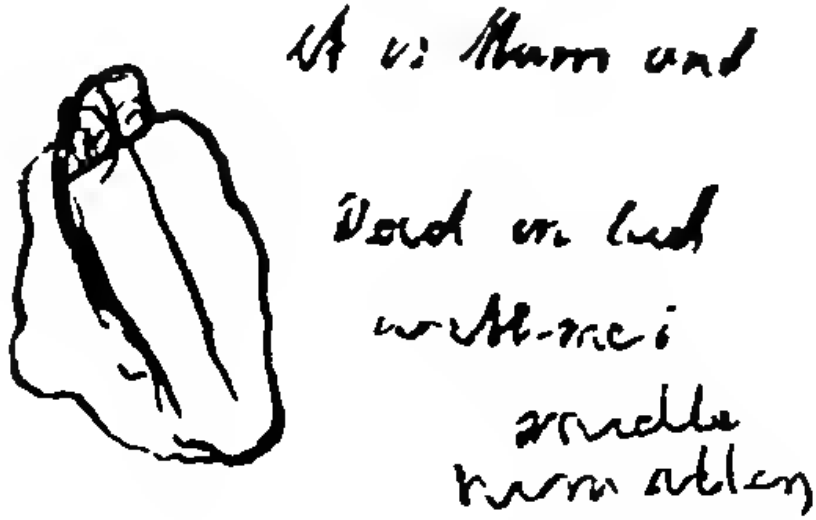

Figure 163

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

It's Mum and Dad in bed with me in the middle

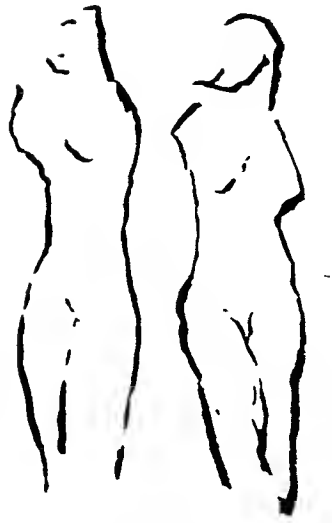

Figure 164

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Woman.
Don't know. Don't know.
Don't know anything about it.
Don't know. It might be Mum.

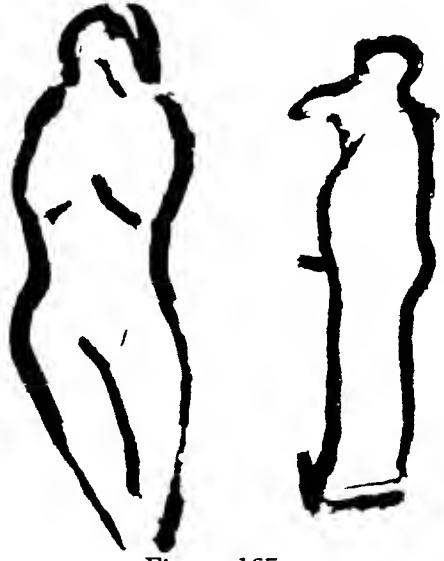

Figure 165

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Could be Mum.
Don't know. (Blocks.)

Figure 166

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Mum and Dad in bed

Don't know (Blocks)

Figure 167

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Mum and Dad (Pause)

Having intercourse (Blocks)

I have seen the room before

Can't remember

A room in pale brown (Blocks)

Figure 168

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Man and woman. (Blocks.)

Figure 169

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Man and woman together.

Don't know anything about it. Don't know.

Suppose it is Mum and Dad.

Figure 170

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.
(No associations asked.)

Figure 171

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.
Mum and me, I think.
Can't see
Baby.
Don't know.
Baby sort of between Mum and Dad.

Figure 172

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Two babies.
One is a girl.
Don't know.
Other might be me.
Should have been a girl.
Don't know. Don't think Dad liked me.

Figure 173

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Dad and Mum with me in the middle.
Dad is wild with Mum, blaming her for something.
Blaming her for having a baby, I think.

Figure 174

CASE NO. 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Dad and Mum together

Put me to one side Don't know (Blocks)

Figure 175

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Don t know

Dad must have lied with Mum because of me

Don't know

Figure 176

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Mum and Dad and I. Don't know anything about it.

Figure 177

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Mum and Dad.

Just me in the middle.

Don't know.

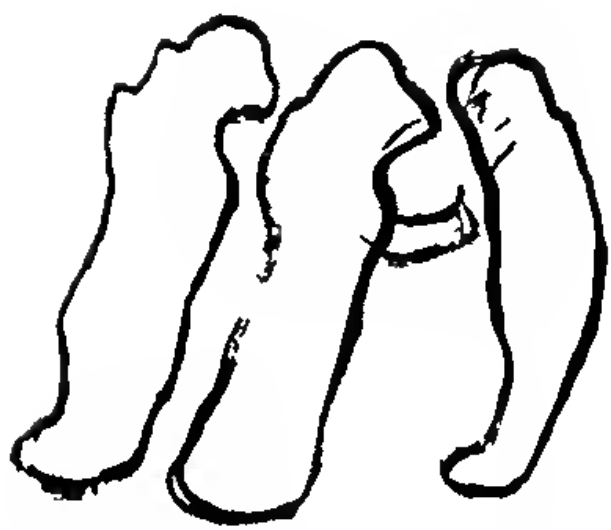

Figure 178

CASE NO 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Babies
Don't know
Two babies
I think this man is either doctor or Dad (Right figure)
Think this is me (Middle figure)
Don't know, can't say who the other is

Figure 179

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Mum.
I think she is worried or sorry.
She is worried about me I think.
I should have been a girl.
Dad wanted a girl.
It would have been better, everybody would have been happier.

Figure 180

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Mum lying down. She is very sick I think.
She has just had me. She is just very sick after I have been born.

Figure 181

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Mum
Don't know
She can't feed me
Don't know, don't know

Figure 182

CASE NO 4 *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Don't know who that is. Doesn't seem like Dad
It seems more like myself
Don't know Don't know Don't know at all

Figure 183

CASE NO. 4. *INHIBITED SCHIZOID YOUTH—PSYCHIC DYSURIA.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Two people, but I don't know who they are.
Can't see anything. Might be Dad and Mum.
but I don't think so. Can't see. Might be Dad and Mum making love, but I don't think it is.
Don't think so.
Mum and Dad I think.
Don't know.
Think it is Mum and Dad but I don't know.
Can't see.

CASE HISTORY NO. 5

The patient is a sensitive schizoid woman, who is lonely and unhappy.

She divorced her husband, who returned from the war mentally unstable and unable to make any adjustment to civil life. She lives alone in her flat; plays her piano; and tries to compensate for her loneliness with solitary drinking.

It was her alcoholism which forced the relatives to seek help for her. She was put into hospital, but remained uncooperative for some time, declining any form of psychological assistance. Eventually she asked for help, and she was treated in hypno-analysis.

Figure 184

CASE NO 5 *UNHAPPY LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Away, away
That's the table
Those are the beds
Window in my bedroom

Comment—Fourth session of hypnosis While sitting in chair, hypnotized by direct stare after a few suggestions of relaxation With eyes open repetitive movements of arm obtained Without previous warning given brush paint and paper Told she will paint something that represents a problem to her Takes brush in a floppy way in her finger tips and paints without hesitation

Figure 185

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Window. (Mumbles. Impossible to hear what she is saying.)
When mum was sick, no one would come.
I walked across to the window.
Mum was sick. (Smudges the wet painting with her finger.)
Mum was sick.
I stood at the window.
Nobody came.
Such pain.
No one came.
I want to go away.
QUESTION. WHAT IS THIS? (Pointing to the two parallel lines.)
ANSWER. Walking to the window.

Comment—The patient had talked at length of her difficulties in nursing her mother in her terminal illness. It was thought that this was a rationalization for her present trouble and that the significant conflicts were probably in the sexual sphere and related to her broken marriage. The present session suggests that the problems expressed about nursing her mother are not just rationalizations.

Figure 186

CASE NO 5 *UNHAPPY LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS
Water water
Used to go down
Three
Got to go home
Dr (—) (Not the therapist)
Water Water
Go down three
I had to go home
They were kind
I had to go home
No one to meet me
Dr (—) B—
Home to the flat
They were kind

Comment—In an attempt to escape from her loneliness and inner tension the patient has recently been for a sea trip The picture is an attempt to represent a ship in which the bow and stern have been omitted The rows of splodges represent water

Figure 187

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Lines.
I don't want to talk about jobs.
They did not meet me.
They did not want me home.
My shorthand.
Want to go away.

Comment—The strokes are a symbolic representation of shorthand. The patient has been trying to get a job as a stenographer, and has been doing extra work in shorthand at home. The two smudges at the bottom left hand corner are due to her dropping the brush when she had completed the strokes.

Figure 188

CASE NO 5 *UNHAPPY LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

It's the windows
John came in there (Points to door)
I wanted to go away
John did not want me to
Did not want to go to court
Did not know what to do
Stuck with my mother
(Pointing to window) Go away with anybody

Comment—Great variation in the diameter of the pupils In this session when first hypnotised her pupils were widely dilated then they became almost pin point but now they are again dilated

The drawing represents a plan of her flat which is on the third floor She went over the lines leading out of the bay window several times The significance of this is not clear It could represent the desire to throw herself out the window as she had suicidal thoughts prior to admission to hospital It could be an attempt to express the idea of getting away from the flat which she had grown to hate

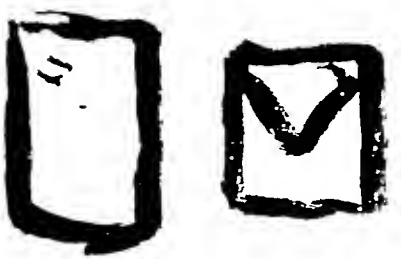

Figure 189

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Box, brooch, mum's. (Mumbles.)
Made me promise to look after it.
Made me promise.
Could not find it.
(—) found it.
I want her to look after it and not lose it.

Comment—There has been a marked change in the patient's facial expression over the past fortnight. There has been a general smoothing out of the wrinkles of her face. The naso-labial folds are much less marked. In consequence, the patient looks considerably younger. The change is not unlike that seen in some patients after leucotomy.

Figure 190

CASE NO 5 *UNHAPPY LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT S ASSOCIATIONS WHILE UNDER HYPNOSIS

I want to go away
Run away (This coincides with her drawing the long line off the page)
Flat next door
Noisy they don t like me
I don t like them
Nasty
QUESTION What s this?
ANSWER Next door I don t like them

Comment—She has started to print the word home This apparently refers to her flat with the unpleasant associations The final letter is incomplete and in its place there is a line leading away from home This seems to represent the idea of going away from home The mark next to home is the adjacent flat occupied by the people whom she does not like

Figure 191

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

I locked the door.
I did not want to go out to anyone.
Want to go away.
The night my mother died.
I wanted to sleep for ever.
Want to get away, and sleep for ever.
QUESTION. What does this mean? (Pointing to the heavy line leading from the room.)
ANSWER. Want to get away, out of the window for ever.

Comment—The painting again represents her flat where her mother died The heavy line leading from the flat represents the idea of going away.

Figure 192

CASE NO 5 *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Nobody liked my music
Played and practised
Dr (—) liked my music
Must get away from them
QUESTION What is this?
ANSWER Piano
QUESTION What is this?
ANSWER Going out that door

Comment—Flops with her head on her shoulder
The representation of the piano is very disorganized The idea of getting away from her flat is again represented by the heavy line leading away off the page

Figure 193

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Tired, don't know where to go.
It's all empty.
Don't like those people, noisy, frightened.
John, mum, noboby.
Horrible people next door.
Nowhere to go.
Mother gets crabby with me in the flat. (This is her first use of the present tense.)
Want to go away out that window.
Could not even play the piano.
QUESTION. What is this?
ANSWER. The place next door.

Comment—The drawing is extremely disorganized. The window is a mere fragment. The marks on the right represent the place next door.

Figure 194

CASE NO 5 *UNHAPPY LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

(Mumbles) Mother wanted me to be happy
She hated John
He was sick too
Mother will never see me happy now
Nothing has happened the way it should have
Go away (Brush runs off paper)
QUESTION What have you painted here? (Pointing to the long black stroke)
ANSWER Away out that door
QUESTION What is this? (Pointing to the black square)
ANSWER Empty room Black.

Comment—She is told Your hand is going to paint something that represents the most important problem in your life'

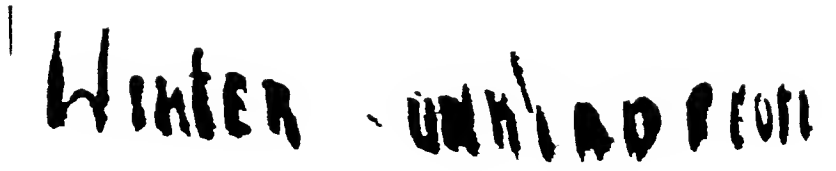

Figure 195

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Nowhere to go.
People talk.
Cold winter.
Unkind talk.
Nobody will come near me.
No warmth, friendliness.
Talk about me.
I would rather die.
Talk about me.

Comment—Prior to hypnosis, says, "I am conscious of what you do and say all the time, keep wondering why I can't fight against it." Afterwards says, "I feel I might have been helping you, but I can't stop doing it. At the time, I feel very tired, very weak, a bit confused. When I look at you I simply can't keep my eyes open. I get a nervous feeling, feel strung up at the start." The brush is held flopping on the tips of her fingers.

Figure 196

CASE NO 5 *UNHAPPY LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

(She goes over the oblique line several times)

Going away from everybody
Going away from everybody
Out the door, and down the stairs
They think I am weak
I am going to do something to show them
I can do things if I try

Figure 197

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Stay there.
Bedroom, stay there.
Must stay there.
So unhappy.
Mother was there.
Must stay there.
Wanted to die there.
Everyone else has got someone.
Nowhere to go.
Could make it nice.
Be happy there.
Nobody knows.
Nobody came. (Emotion.)
I must stay there.

Figure 198

CASE NO 5 *UNHAPPY LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Mum dying
Wanted to die myself
So tired
Wanted to die to go away
Used to lie and watch her
So sick
Did not want her to die
Knew I would be so lonely
Someone said John was going to die but he did not (Smudges drawing)
Sleep forever

Comment—Paint brush runs off paper Several times she goes over her line leading away

Figure 199

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

All the people there.
I was in my bedroom the day after mum died.
They told me to go back to work, that I was lucky to have a flat and a job.
Said I had no one to think about but myself.
Lucky to have my flat.
All talking, saying I was lucky.

Figure 200

CASE NO. 5 *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

I had to get away
I went away
Spent such a lot of money
Felt better, got fat
Did not think I would ever come back
Had to come back
Came back to the flat
Worried all the way coming back
QUESTION What is the picture?
ANSWER Sister's house The drive Came back there

Figure 201

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Did not want to go back.
I hated my sister's garden.
Mother wanted to go back, to be home.
Always talking about it.
Dad built it for mum.
She wanted to go back there, to have a garden.
She was always worrying about it.
They are all interested in their own families and houses.
Mum and I.
Could not leave her.
John wanted my flat too.
Did not know what to do.
QUESTION. What is this place?
ANSWER. (—'s) Road.

Figure 202

CASE NO 5 *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

Just nothing nothing there
No one there no one to talk to when I come home
Tired, and no one there
I wanted to die
Dr (—) asked me if I cried
Go home and cry
Drink *but not hospital*
Don t remember All so confusing
Mother was sick but she did not go to hospital
It's all my fault
Mum would hate it Would be disappointed
I was spoilt Could not take it

Comment—In the eight paintings done this session, there is no mention of sex or her marriage, and very little mention of alcohol The picture again represents the plan of the flat

Figure 203

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Everybody talks about me drinking.
Man in the flat.
Hate it.
That's why I'm here.
Not sick—hate it.
Harping on it, harping on it.
Doctors won't let me go back.
Everybody talks about it.
John drank—doctors never talked about it to him.
He was very sick.
Hate it.
Everyone talks about it all the time, and I hate it. (Expresses emotion, and smudges picture with her finger.)

Comment—Two days ago, in order to try to get a job, she had left hospital for the day. She went to her flat, and invited in a couple of men friends. She says she offered them a drink. They were absolutely insistent that she also should have a drink. After some resistance, she had a sherry. This conflicted with a post-hypnotic suggestion given some ten days previously. She says the sherry tasted awful. The nausea was such, that she had to lie down. She became anxious and confused, and could not return to hospital until picked up by a relative.

Figure 204

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

(Holds brush loosely in her fingertips)
Everyone talks about me
The man from the office knew I was in hospital
Should have kept on with my music
Get away from it all (Points to the bottom figure)

Comment—The sherry glass apparently refers to the recent episode. The second figure is the music stand of a piano, and the square on the right is her prize for music. The bottom figure is her 'Going Away' symbol, which she has used before.

Figure 205

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

So much has happened.
I knew John had courage.
Ribbons, John's ribbons.
He was weak, but I did not think so.
Mother always said I would be alright.
She was wonderful to me.
Always so tired when she was sick—terribly tired.
Let mother down.
John let me down.

Figure 206

CASE NO 5 *UNHAPPY LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS

(Goes over the stroke several times with some emotion)

Away from everywhere away from everybody

Worrying everybody

Family

Not fair to my family

Not fair to my doctor

Comment—Two days ago took an overdose of sleeping tablets and was found deeply asleep but not comotose on the floor of her room

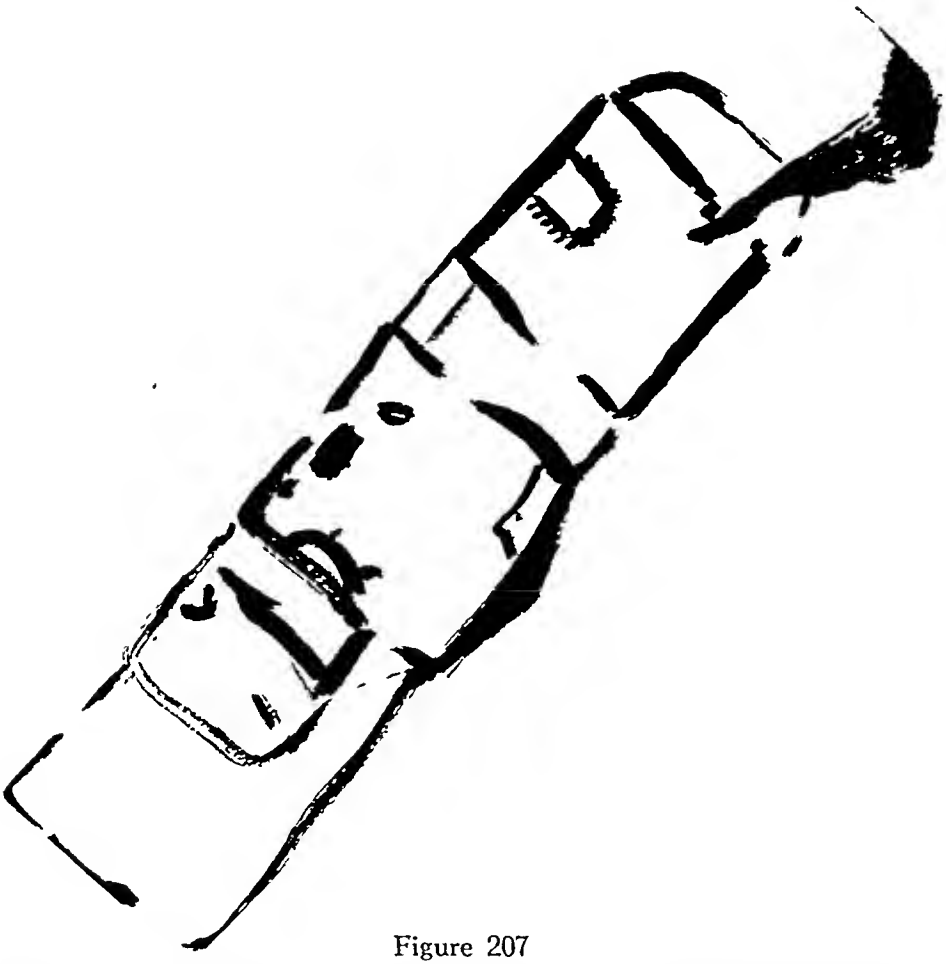

Figure 207

CASE NO. 5. *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL.*

PATIENT'S ASSOCIATIONS WHILE UNDER HYPNOSIS.

Must go back.
Die there.
Everyone talks about me.
Want to get out of there.
Must get to work.
Nobody there.
I was going to feel like going back.
Must go somewhere.
Everyone talks about me.
No one to talk to me.
She wanted my flat for her brother.
Don't like (—).
Must go to work.
Must get away.

Comment—A carpenter starts hammering loudly in the next room, but the noise does not disturb the patient.

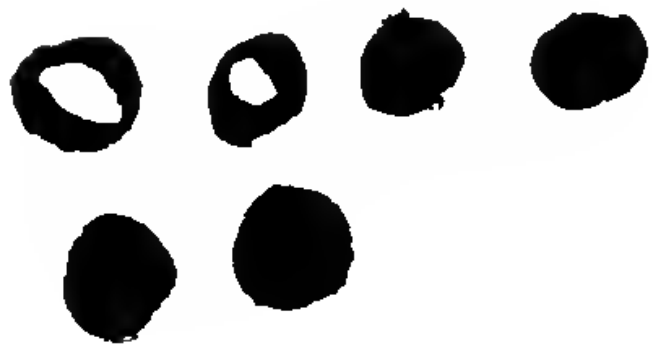

Figure 208

CASE NO 5 *UNHAPPY, LONELY WOMAN COMPENSATING WITH ALCOHOL*

PATIENT S ASSOCIATIONS WHILE UNDER HYPNOSIS

(Gets stuck on the last circle Keeps on painting round and round it)
I could take the tablets go to sleep never wake up never wake up, never wake up
I have not got anybody
Can t do anything
Other people can do things
Can t do anything
Talk about me all the time
Worry people
I worry my family
I don t see things the way they do

Comment—The painting represents the tablets which she took two days ago Apparently the two light tablets are the ones she was allowed to take and the four black ones are the additional tablets which she should not have taken

At this stage in the treatment a change was made from hypnotic painting to modelling under hypnosis

Chapter 10

GENERAL CONSIDERATIONS

Truly, the souls of men are full of dread.
Richard III Act 2, Sc. 3

1. PROBLEMS IN TECHNIQUE

The difficulties of hypnography relate to the maintenance of adequate hypnosis, to the ventilation of the repressed material, and the integration of this material with waking psychotherapy. When due consideration is given to the matters of rapport and motivation, and with an understanding of the unconscious defences against hypnosis, the commonly described difficulty of the patient not being hypnotized simply does not arise. The evidence would seem to be overwhelming that, as long as the above considerations are borne in mind, any patient who really desires treatment by hypnotherapy can in fact be hypnotized. The humiliation of being confronted with a patient who has not gone into hypnosis is an experience which has been quite foreign to the work on hypnography.

Although all patients have been hypnotized without undue difficulty, at times there has been trouble in achieving or maintaining adequate depth of hypnosis for hypnotic painting. This has usually been overcome by using the patient's defences against himself in variations of the dynamic method. Some patients, although hypnotized, did not reach sufficient depth, and in these cases hypnography was not attempted.

The successful elicitation of the relevant repressed material seems to depend very much on an appreciation of the dynamic aspects of the situation. In hypnosis it seems that unconscious conflicts spontaneously seek ventilation. Defence mechanisms function to prevent this ventilation. The defences which ordinarily operate in waking psychotherapy are still present, but with the hypnotized patient they are rather less active. Their place is

largely taken by defences peculiar to the hypnotic state, and in the case of hypnography, to defences peculiar to hypnotic painting The situation is essentially dynamic The unconscious conflicts come closer to expression as the hypnotic state reduces the effectiveness of the repressing mechanisms Appropriate suggestions from the therapist further stimulate ventilation The traumatic material on the verge of awareness initiates the activity of further defences The therapist circumvents the defences by switching his suggestions to other areas where the defences are not effective The process continues until the repressed psychic material gains expression, either grudgingly bit by bit, or in an avalanche carrying all before it

The repressed conflicts are elicited by the process of hypnography How is this best used to help the patient? At present this constitutes a real problem in technique, and requires further study Two things are clear Provided adequate depth of hypnosis is maintained, the traumatic nature of the ideas ventilated does not unduly disturb the patient On the other hand the presentation of these ideas to the waking patient may precipitate extremely acute anxiety The present work has been done in consulting room practice, in which the patient returns home after the treatment session In such practice, the mobilization of any undue anxiety is to be avoided

There are two practical ways in which the patient may gain insight without much risk of sudden anxiety If a patient is allowed to ventilate traumatic material in several sessions of hypnography, it seems that he gradually achieves some degree of insight without any waking psychotherapy at all The process may be slow, and it may be incomplete, but nevertheless it is very real It is often coincident with symptomatic improvement It may be shown in the character of the paintings The portrayal of basic conflicts may give way to more superficial conflicts or reality problems Thus a patient over a number of sessions made a series of paintings relating to the gallows The recurring theme was that she was going to be hanged because she was going to kill the man who had wronged her This theme gradually decreased in frequency and was replaced with more superficial themes, without waking psychotherapy

This process is aided by the omission of any suggestions of amnesia for the session, no matter how disturbing it might have been. This allows the patient's natural defences to come into play. He remembers what he can bear, and has an amnesia for the rest. In subsequent sessions the amnesia becomes progressively less complete.

A more obvious way of using the material to help the patient is to integrate it with waking psychotherapy. This is the method of choice, but it involves some difficulties. The gaining of insight, the process of becoming aware of the nature of the conflicts, must be very gradual if acute anxiety is to be avoided. The time when the patient is wakened from hypnosis would seem to be the logical time for such psychotherapy. It is then that the patient's defences have been shaken by the hypnography, and the repressed material is near the threshold of awareness. The difficulty is that the patient has to leave the consulting room, and return home and go about his ordinary business. He must not be sent out, either emotionally disturbed, or exhausted from the ordeal of treatment. On account of this it is felt wiser to allow the patient twenty minutes or so in hypnotic sleep to compose himself after the hypnography, rather than embark on a possibly disturbing session of psychotherapy. So it has been the custom to intersperse sessions of hypnosis with sessions of psychotherapy according to the requirement of the therapeutic situation. In these sessions the patient's defences have re-established themselves. The sessions are less productive. Progress is slower; but on the other hand, there is less risk of untoward incidents.

In two or three cases, counter-suggestions have provided quite a problem. Hypnosis is not yet fully accepted as orthodox medical treatment. This applies not only to laymen, but also to quite a high proportion of medical practitioners. Because of this, it has been the practice to discuss the patient's treatment by hypnosis with both the patient's relatives, and the referring doctor. But this has not always been possible, and on occasion it has been found that the patient has been subjected to extremely active counter-suggestions from the relatives. Patients have been told that they will lose their will from hypnosis; that it will make them worse; that it will even make them mad. On more than one oc-

casion a well-meaning but ill-informed local doctor has inadvertently given non verbal counter suggestions by merely expressing surprise at the patient being treated by hypnosis Counter suggestions in the early stages of treatment tend to weaken rapport, and so make the passive induction of hypnosis more difficult

There is the evergreen problem of the male therapist hypnotizing the female patient Should there be a third party present? It is felt that this is a problem which should not be dismissed lightly From the patient's point of view there are a number of factors She might feel that proper decorum requires the presence of another person This does not happen often these days, but when it does there should be no objection to the patient having her wish Other patients might desire the presence of a third party for protection for protection against *seduction* If it is thought that this is the patient's reason for desiring a third party, then it is well to reconsider the whole question of hypnotherapy with the patient It means that rapport is inadequate, and it may mean that the patient is likely to misinterpret actions of the therapist From the factual point of view, in hypnosis, just as in any other branch of medicine, the patient s protection lies in the reputation of the physician There is another reason why some patients desire a third party They simply feel more at ease if someone else is present They can relax better In such circumstances the patient's wish should be granted, but such a desire on the part of the patient in most cases indicates rather poor rapport

The therapist s reasons for having a third party are actually more realistic than those of the patient During hypnosis the sexual feelings of the patient may become roused She may in fact experience orgasm It would be easy for such a patient to wake from hypnosis with the feeling that the therapist had interfered with her

Sexual feelings are more likely to become aroused in patients undergoing hypnoanalysis than in patients being treated by hypnotic suggestion In hypnoanalysis patients may become stimulated from the ventilation of sexual conflicts In this respect it is interesting to note that some therapists report that a great number of their patients become aroused in this way, while

others state that it happens only extremely rarely. Of those therapists, who have many patients who become sexually aroused, it would seem likely that there is something in their manner which inadvertently acts through non-verbal suggestion to convey erotic ideas to the patient.

Hypno-analysis may complicate the problem of the third party in another way. It is a comparatively easy matter for the therapist to accustom himself to using authoritative methods of induction in the presence of on-lookers. But the passive induction required for hypno-analysis is usually more difficult in front of spectators. It requires very good rapport with the patient; and it requires a considerable degree of psychic integration on the part of the therapist. Accordingly in hypno-analysis there is always present the motivation for the therapist to rationalize against having a third person present.

The procedure followed by the author is quite simple. If there is any reason for having a third party for the therapist's sake, the nurse remains in the room during the physical examination, during the estimation of suggestibility, and during hypnosis. The matter is not discussed with the patient at all. This procedure is followed with any patient who has a history of erotic attachments to other doctors, and with hysterics of the pseudo-seductive and erotic type. If there is no indication for a third party from the therapist's point of view, the patient is simply asked, 'Would you feel more comfortable with nurse in here, or would you sooner that she remain in the other room? Some patients like nurse in here, others don't." If the patient desires a third party, then the patient's motivation must be assessed. In actual practice most female patients have been hypnotized without any third person present.

2. THE DANGERS OF HYPNOGRAPHY

There are hazards in almost any form of medical treatment. There are hazards in hypnography, and they are quite real ones. They concern the dangers of hypnosis, and the dangers of this particular form of reductive psychotherapy.

The dangers associated with the induction of hypnosis are detailed and evalued in a number of works on general hypnosis.

Of the patients treated by hypnography there has been no evidence of any over-dependence on the therapist It would seem that this danger is much less in hypnotic treatment based on insight, than in suggestive hypnotic treatment The full psychiatric examination of the patient prior to hypnosis should practically exclude the danger of precipitating a pre-psychotic patient into a frank psychosis A clear assessment of the patient's motivation for hypnotherapy is very necessary Otherwise, patients who are driven to seek hypnosis by perverted unconscious drives, may he accepted for treatment Similarly, a therapist who obtains unconscious satisfaction in the practice of hypnosis is a potential danger to his patients

The dangers due to the hypnotic state, which have actually been encountered, have been of little consequence At each session, after the paintings have been completed, it has been the practice to allow the patient half an hour's rest in hypnotic sleep before being awakened to go home Early in the series, two or three patients complained of stiff necks and painful joints The muscular relaxation in deep hypnotic sleep is very complete The head and the limbs are likely to slip into unusual positions, and the joints lack any support from the toneless muscles Meticulous care is now taken to see that the head and limbs rest in normal postures so that there is no undue strain on the joints As a result, complaints of stiff neck or sore joints have ceased

Occasionally a minor difficulty has arisen through the patient's misinterpretation of some word or gesture This becomes significant by virtue of the intensity of the rapport between the patient and therapist In ordinary waking psychotherapy the patient's reaction to the therapist is determined by the therapist's over-all behaviour A minor misunderstanding of something said by the therapist is bad enough, but it is not disastrous With the hypnotized patient it is different Every word, and all the small spontaneous gestures of the therapist, become significant Any misinterpretation may have an effect far beyond the logical implication of the situation

When it is first encountered, the failure of the patient to wake from hypnosis is quite an alarming experience for the therapist This has occurred on two or three occasions Each time the

hypnotic session had passed without any complications, and the patient had been left in hypnotic sleep before waking. During the session each patient had carried out the suggestions without hesitation. But when it was suggested that the patient should wake up there was no response whatever. The patient continued in deep sleep. The answer to this alarming situation lies in the psychodynamic interpretation of behaviour. What is the meaning of the patient's behaviour when he refuses to wake up? In each of the cases under discussion the behaviour was interpreted as an expression of protest, self-assertion, or hostility. The situation is treated in a similar way to a defence mechanism. The suggestions are switched to another area in which the patient's actions do not apply. Instead of being told, "You will wake up when I count to three," the patient is given suggestions of calm and ease, and told, "You can wake up when you want to." In each case the patient has woken up within a few minutes. With the change in the manner of formulation of the suggestions, the patient is no longer able to express hostility by remaining asleep, so he wakes up. This matter was discussed in waking psychotherapy with one of the patients. The incident had followed her first attempt at hypnography. During the hypnotic painting she had clearly expressed the idea of protest in one of her paintings. She subsequently said that she had been doing everything I had said, even to painting. I had told her to go to sleep. It was beautiful just lying there asleep, so utterly relaxed, peaceful and happy. Then when I told her to wake, she had felt, "Why should I; he tells me to do too many things; damn him. I will stay like this."

Patients not uncommonly deny that they have been hypnotized. Sometimes a patient who has been lightly, but definitely hypnotized will rationalize the experience, and ask when is he going to be hypnotized. This attitude is usually evidence of psychological resistance. It can be met in either of two ways according to the personality structure of the patient. The passive approach is to merely reassure the patient that things are going alright. The more active approach is to tell the patient that at the next session he will be able to see real evidence of hypnosis. On this occasion repetitive movement of the arm can be induced

with the eyes open, and the patient strongly challenged to stop the movement This convinces the patient, and sometimes has an accelerating effect on the progress of treatment

A practical danger is that the patient may become drowsy on the way home from treatment One particular patient lived in the country, and after each treatment was driven home by a friend He was normally a man who habitually had very great difficulty in getting to sleep, nevertheless he always fell asleep in the car on the way home after treatment It is obviously dangerous to allow a patient to drive himself home until it has been thoroughly established that his pattern of behaviour after hypnosis does not involve drowsiness

In any form of reductive psychotherapy there is the danger of the patient becoming too suddenly aware of repressed material This danger is present in waking psychotherapy, but it is very much greater in hypnotherapy The hypnotic state may allow the sudden surge into consciousness of repressed material The danger of untoward reactions on this account is greater in hypnography than in verbal hypno analysis On account of the permanence of the painted symbol, the ordinary psychological defences cannot deal so well with anxiety from the conflict when it is expressed in painting, as when it is expressed in words This danger is minimized by ensuring a proper depth of hypnosis for the making of the paintings, and for the giving of the associations

the patient was fit to return home within an hour without the necessity of any sedation.

When these untoward reactions occur, it would seem to be very important to increase the depth of hypnosis with the least possible delay. The instinctive reaction on the part of the therapist to waken the patient when something goes wrong must be resisted at all costs. Safety lies in deeper, not lighter, hypnosis. With increasing depth of hypnosis, suggestions of calm and ease can be given. The patient is then put into a hypnotic sleep and allowed to allay his anxiety in half an hour's rest.

One patient became disturbed in a way which he did not understand. It was after his first session of hypnotic painting. When he came a week later for further treatment, he said that he had been sleeping badly. He was worried each night by a recurring dream. He was always drawing something. Sometimes he was a school teacher at the blackboard; sometimes he was demonstrating some technical matter to work-mates; but in every case he was always drawing something. He made the comment that he had never previously had that type of dream. He was asked if he did not remember drawing things on his last day of treatment. He was obviously surprised at the question, and denied that he had drawn anything. So he was shown the drawings he had made. This happened early in the work and they were actually pencil drawings, not paintings. He had no recollection of having seen the drawings before, and had no idea of what they were about. The associations which he had given to the drawings were then read out. The meaning of the drawings then became clear to him. He was full of wonder that he could have made such drawings, and know nothing about it. At the conclusion of subsequent sessions he was given suggestions of restful sleep for each night, and the disturbing dream did not recur.

Figure 209 An inhibited and rather religious youth became lighter in hypnosis as he was giving associations to this painting His awareness of having painted a female figure produced a mild but definite anxiety reaction

Figure 210. This figure was made by the method of structuring initial random marks. It activated the patient's latent guilt and anxiety, as seen from his associations "Paint M, then change to a figure. Some kind of peculiar pre-historic animal, or a disfigured creature. Gave me a fright. My first wife had an abortion, had to bury it. It looked like this. Feel all nervous."

Figure 211 When asked to draw with a crayon, a young man commenced a rhythmical back and forth movement He became more and more preoccupied with it, and the sexual character of the activity soon became apparent to the therapist Hypnosis became lighter, and the patient became aware of the sexual significance of what he was doing A sudden profound anxiety reaction ensued

Figure 212. The patient defended himself against giving relevant associations to this universal symbol, until a fountain pen was moved in and out of the mouth of the "U." This provoked an extremely severe anxiety reaction.

Figure 213. Even the deeply hypnotized patient retains some capacity of defence and self-expression. The patient was being trained to have her baby under hypnosis. Although hypnosis was such that she was anaesthetic to having her skin clamped in artery forceps, nevertheless she retained the ability to make the protest seen in this painting.

Another interesting observation is that the work on hypnography has provided two incidents which might be interpreted as evidence of telepathic communication between the therapist and the patient. The first incident occurred early in the series. A deeply hypnotized patient had completed a painting and was preparing to commence another. In anticipation of writing down her associations, I casually wrote the number of the painting on a pad of paper. The patient quite spontaneously wrote the same number with the paint-brush. It was impossible that she had seen the number which I had written down, and there was no suggestion for her to write a number. I then wrote another number and suggested that the patient write a number. She wrote down the same number. The process was repeated several times with the patient scoring a high proportion of successes. It was then realized that the patient had come to consultation for the cure of her neurosis and not for experimentation; so the matter was discontinued. The second incident occurred when a patient asked the author if he believed in telepathy. The patient readily agreed to experiment. It was arranged that I should write down a number, and at the same time I would suggest that the hypnotized patient should write down a number. The outcome was that the patient scored three successes out of five trials. I was very impressed with this, and arranged a witness for further trials, but in a further five attempts the patient scored no successes at all. It seems that this is a field which would provide scope for detailed critical investigation.

It was at first thought that patients who had previously had extensive psycho-analytical treatment might present special problems. This has not been so. A very highly intelligent business executive, who had previously had a year's psycho-analysis, and who was particularly well versed in psychological literature was being treated for impotence. He had a sound knowledge of the mechanisms of suggestion. In view of this, care was taken to make the induction as passive as possible. Yet the patient several times made the comment to the effect that he knew the therapist was influencing him by the strength of his mind. There was no possibility that the patient was psychotic. Rather similar ideas of influence were expressed by a non-psychotic physician, who again

Chapter 11

THE ASSESSMENT OF HYPNOGRAPHY

There are more things in Heaven and Earth, Horatio,
Than are dream'd of in your philosophy.
Hamlet Act 1, Sc. 5

1. THE ASSESSMENT OF HYPNOGRAPHY IN RELATION TO THERAPY

Hypnography is a rather complicated procedure. It requires both experience in hypnosis, and a real understanding of the dynamics of psychotherapy. Psychiatry already abounds in complex techniques which take many years to master. Is there any justification in attempting to add yet another such procedure? It would seem that an answer to this question could only be given when the technique has been fully investigated by others than the originator.

In any assessment of the value of hypnography in therapy it must be constantly borne in mind that hypnography is not a method of treatment in itself. It is merely an aid to hypno-analysis, which is itself an aid to psychotherapy. As an aid to hypno-analysis it would seem that hypnography has certain merits. It is obviously a help with those patients who do not readily talk under hypnosis. It has also been the experience in the present study that some patients have ventilated significant material in hypnography which was not ventilated in waking psychotherapy, narco-analysis, or verbal hypno-analysis. The reason for this is not clear; but it may be associated with the fact that the common defences against verbal expression are often not applicable to graphic expression.

There is another factor. Hypnography aims to give the patient insight. But it is not a pure form of therapy, in that other mechanisms beside insight contribute to the therapeutic effect. In this respect it must be remembered that no form of therapy is com-

pletely pure. Even formal psycho-analysis cannot be freed from the suggestive effect of the patient visiting the therapist. But in hypnography, suggestion and other side effects assume much more significant proportions. There is unmistakeable evidence that the very fact of being hypnotized has a very strong suggestive therapeutic effect. This functions in the complete absence of any verbal suggestions. Of necessity, the assessment of the effect of the insight obtained *in hypnography is complicated by this* suggestive element which the treatment carries with it.

This is further complicated by still other factors. The degree of rapport between patient and therapist has an effect on any form of treatment. The rapport is effective by enhancing suggestion, but it may also have a further effect independent of suggestion in which it operates in the way of symbolic love. The intense rapport of hypnosis is a necessary concomitant of hypnography, and so must to some extent obscure the effect of insight.

Abreaction is known to have a therapeutic effect of varying duration in different types of nervous illness. It has been shown that abreaction, either during the actual making of the paintings, or in the subsequent elicitation of the associations, is often a prominent feature of hypnography.

Any assessment of the therapeutic value of hypnography must give due consideration to the fact that the conflicts are expressed both graphically in the paintings, and verbally in the associations. It has been shown that the two different modes of expression evoke different psychological defences. The patient may be able to defend himself in one area, but may be quite unable to do so in the other area. The quality of permanence in graphic expression not only makes the achievement of insight so much the easier, but also helps the patient to develop the ability to tolerate the conflict. This latter applies particularly in the development of a tolerance of present day reality conflicts.

It is seen then that hypnography is a technique in which the prime aim is to help the patient to achieve insight, but at the same time it involves other mechanisms, suggestion, rapport, and abreaction, which have a therapeutic effect quite independent of insight. Undoubtedly a great number of psychiatrists believe that the achievement of insight is the only really effective thera-

peutic mechanism. To these men other therapeutic agencies only obscure and retard the effect of insight. Yet all of us, who practice psychiatry, know of patients who have made apparently complete and lasting symptomatic recovery, and who certainly did not achieve full insight. We all know of others who remain plagued with nervous symptoms, and who at the same time would appear to have very full insight. It sometimes seems that insight itself is a receding mirage, and perhaps should be considered as a philosophical rather than a psychological problem. In view of these considerations, it might be that hypnography could become a useful way of combining a form of insight therapy with the adjuncts, suggestion, rapport and abreaction.

The present work has been done exclusively with chronic psychoneurotics, all of whom had had extensive treatment by other methods. Three patients had been treated by psycho-analysis for long periods. As a group, the patients would be regarded as having particularly bad prognoses. It would seem likely that even better results would be obtained with patients who had a shorter duration of illness.

There is no attempt to present any statistical survey of the results of hypnography. There are several reasons for this. The technique is still experimental, and the present publication aims to be primarily descriptive in the hope that the technique will be tested in the hands of other workers. From the point of view of any statistical analysis, there is the additional difficulty of assessing the effect of hypnography independently of the concomitant psychotherapy; but there is no doubt that the clinical impression of the results of treatment is very favorable indeed.

2. HYPNOGRAPHY IN RELATION TO THE THEORY OF HYPNOSIS

Hypnography is something new. Does it throw any light on the old problem of the nature of hypnosis itself? Any general discussion as to the nature of hypnosis is beyond the scope of the present work; but hypnography does throw some light on at least some aspects of hypnosis.

The making of the paintings gives ample evidence that hypnosis is a highly dynamic state. The depth of hypnosis changes

from moment to moment according to the nature of the material being projected in the painting The patient, absorbed in some incident of the past, drifts deeper and deeper He regresses He is a child again Then perhaps he abreacts Hypnosis becomes lighter, and he returns to the present The whole situation is essentially variable, and the variability is essentially purposive

These studies in hypnotic painting show that there is also another type of variability There is a simultaneous variation in the depth of hypnosis in different areas of ego function In one respect the patient is deeply hypnotized, in another respect the hypnosis is only light A patient may go into a profound hypnotic sleep, in respect to which he is deeply hypnotized, yet the same patient in respect to painting may be so lightly hypnotized that he is in danger of waking if he is asked to paint Another patient may be deeply hypnotized and project deep seated conflicts in his painting, but as regards sleep may be so light that his restlessness makes sleep impossible The depth of hypnosis would appear to be determined by unconscious mechanisms analogous to psychological defences The logical conclusion from these observations is that the classic concept of hypnosis as a fairly static level of mental functioning is no longer valid Hypnosis is obviously a highly dynamic constantly varying state

In 1886 Liebault described degrees of hypnosis He used the descriptive terms, "refractory," heavy somnolence ' light sleep," "deep sleep,' 'very deep sleep light somnambulism" and 'deep somnambulism" Bernheim made slight modifications to this classification This way of describing the depth of hypnosis in different levels has persisted unchanged to the present day The important observation for the present discussion is that the concept of levels of hypnosis remains valid only so long as the suggestions follow a fairly set pattern For the induction of hypnosis, Bernheim habitually concentrated on suggestions of sleep and therapy was by the authoritative removal of symptoms As long as some set pattern of suggestions is maintained, it is valid to speak of different patients achieving different levels in depth of hypnosis But, if the pattern of suggestions is varied the level of hypnosis varies With the dynamic method for the induction of hypnosis there is no set pattern of suggestions and with the

patient ventilating conflicts in hypno-analysis there is no set routine similar to that of Bernheim's suggestive therapy; but somehow the idea that depth in hypnosis is a static quality persists in modern works on the subject. Experience in hypnography shows clearly that not only does the depth of hypnosis vary from moment to moment, but also that different elements of the personality can vary in depth of hypnosis independently of each other. The classic concept of levels of hypnosis cannot be reconciled with these observations.

Hypnography also throws light on another aspect of hypnosis. For half a century, writers have been commenting on the apparently hysterical nature of much of the behaviour of the hypnotized subject. Charcot was so impressed with it that he was led to the belief that hypnosis itself was an hysterical condition which could be induced in certain constitutionally predisposed persons. Other observers have emphasized the dramatic qualities and the apparent acting of this hysteroid behaviour; and they have come to regard it as evidence of simulation, and have concluded that hypnosis is a kind of an act, which can be put on at will. During the first attempts at hypnography, the author was very worried by the odd way in which the brush was held by the patient. It was so odd, so completely unrealistic, that it was thought that the patient was not properly hypnotized, that he must surely be simulating. It was subsequently found that many other patients behaved in the same way, even when there was no doubt that they were quite deeply hypnotizd. Sometimes the oddness of the behaviour would be extreme. A deeply hypnotized patient holds the brush between the thumb and little finger. The brush flops about all over the place, but at the same time the likeness of some object is effectively painted. It gradually became apparent that the hysteroid manner of holding the brush was purposive. It was purposive in two ways. In the first place it acted as a defence to try to save the patient from disclosing repressed material by the painting. Secondly, it was a means of expression. It expresses the idea, "You can see a hypnotized person can't paint."

These principles can be applied to the hysteroid behaviour of the hypnotized subject in general. If the patient walks in a strange way, his peculiar gait is usually due to a purposive at-

tempt to express some meaning, rather than the result of loss of motor ability due to the hypnotic state A strange posture, or an odd facial expression can be similarly interpreted, and so on, through the whole range of hysteroid behaviour which is seen in hypnosis

3 THE ASSESSMENT OF HYPNOGRAPHY IN RELATION TO SYMBOLISM

The interpretation of symbolism has always been a rather speculative matter It is largely determined by the subjectivity of the interpreter, his training and his own basic beliefs That this is so, is seen from the vastly different interpretations of similar symbols by the two great modern schools of dynamic psychology, the Freudian and the Jungian In the ultimate analysis, there can be nothing definite while such differences of opinion still exist Much of the work on symbolism really resolves itself into a matter of the expression of opinion

But with hypnography the situation is quite different The hypnotized patient actually tells us the meaning of the symbol which he has made There is no speculation in the matter The subjectivity of the interpreter does not come into the question

The most significant feature has been that a great number of apparently phallic and female symbols have been interpreted by the patient as individual symbols This has occurred over and over again Symbols which, on appearances, would be regarded as classic phallic symbols are repeatedly given some special meaning by the patient In subsequent paintings the same symbol tends to recur, and each time is given the same special meaning

In hypnography, it is beyond doubt that many apparently phallic symbols are in fact individual symbols The question naturally arises as to whether the same might not be true in other areas of symbolism besides hypnography In an attempt to clarify the problem, some work has been done on the symbolism of paintings done in the waking state by psychotic and pre-psychotic patients It has been a matter of obtaining many associations from the patient to each of the symbols in the paintings This work suggests that many of the apparently phallic symbols in schizophrenic painting are in fact individual symbols But it seems

that this process occurs less frequently in schizophrenic painting than in hypnotic painting.

As a general rule the hypnotized patient has not much need to defend himself against ideas of sexual congress or even incest. A patient quite openly depicts himself having intercourse with his mother. With the hypnotized patient, the sexual organ itself, or the sexual act itself, can be fully portrayed. There is no longer the same need for psychological defence by the use of the classical phallic symbolism.

The matter is further complicated by the undoubted fact that the same symbol may have different meanings at different psychic levels. With this in mind, it has been thought that the apparently phallic symbols which were interpreted as individual symbols might with deeper hypnosis be given a truly phallic interpretation; but there has been no clear evidence in this respect.

These observations may have some relevance in fields far removed from therapeutics. For instance, there is the question of interpretation in modern art. The surrealist projects material from his unconscious; either directly, from dreams, from consciously evoked phantasy, or from the conscious manipulation of symbols. The painting is judged from the point of view of integration, tonal qualities and general artistic workmanship; but in addition to this, it is also given a meaning. It is probable that persons unsophisticated, and uninitiated in matters of symbolism, can somehow feel the meaning of surrealistic painting. The process is not logical or intellectual, but it would appear to take place through some unconscious understanding of this symbolism. The awareness of the meaning is always vague; it cannot be easily expressed or verbalized. Such is probably the ideal situation; but these days most people who view modern pictures have some knowledge of symbolism. There is the tendency for the meaning of a painting to be deduced by the conscious evaluation of the various symbolic elements. Our study of hypnotic paintings would suggest that such a process is likely to lead to the misinterpretation of the meaning from the confusion of individual symbols with universal symbols. These considerations apply only so long as the artist is genuinely projecting material from his unconscious. But it is obvious that many artists, who have a knowl-

edge of symbolism, construct paintings by the conscious integration of various symbolic elements. These pseudo-surrealistic paintings are not likely to be misinterpreted in the same way as the others, because the artist naturally uses his symbols with the classic and accepted meaning; and avoids the use of the confusing individual symbols.

It would seem possible that hypnography could become a means of our gaining a greater understanding of the whole process of symbolism.

4. HYPNOGRAPHY IN RELATION TO PSYCHOLOGICAL THEORY

The incest wish has been the occasion of considerable dispute in psychological theory over the past half-century. Most of the evidence for its existence is indirect rather than direct. In this respect, the hypnotic paintings have provided some direct evidence. A young man in his middle twenties paints a picture of himself having sexual congress with his mother.

This painting of incestuous sexual relationship has a further implication in psychological theory. It has often been stated that the material which the patient ventilates in hypno-analysis is in fact true. This view is even more widely held in respect of narco-analysis. The term, "truth drug," is a reflection on this belief. The matter has even extended beyond the limits of psychiatry. In some countries there has been considerable discussion in legal circles concerning, not only the admission of evidence obtained by the "truth drug," but also the validity of such evidence. The study of hypnotic paintings shows beyond all doubt that phantasy material may be produced. Such material is true in the psychological sense in that it is a product of the psyche, but of course it is not true in the factual, legal sense of the word.

Narco-analysis is essentially an imitation of hypnosis effected by the simple pharmacological technique rather than the more difficult methods required for the induction of hypnosis. If false evidence can be produced under hypnosis, then almost certainly false evidence may be produced under the "truth drug."

Hypnography has a bearing on psychological theory in another respect. This concerns the manifestation of anxiety. In the whole

of the series of patients treated by hypnography, anxiety was produced only in response to the threat of loss of control, and the threat of awareness of psychological conflicts. Other matters never caused anxiety; not even the sudden and unexpected production of painting materials and the suggestion to paint. This, of course, is consistent with modern psychological theory; but it would seem to lend weight to the idea that anxiety is not produced by other than biologically or psychologically significant threats. Nevertheless there are essential differences between the hypnotized and the waking state, and it may be that the rapport of hypnosis together with the presence of the therapist has some effect in warding off anxiety.

"Dynamic" is the word which is being used more and more in the descriptive writings of modern psychiatrists. If there were ever any doubt as to the highly dynamic nature of the functioning of the mind, no more convincing proof could be obtained than the study of hypnography. If there is one impression, more than another, which the therapeutic use of hypnotic painting leaves with the therapist, it is one of the intense mobility and continual fluctuation of the psychic processes.

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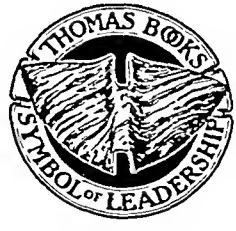

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